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CLICK HERE FOR MENTAL HEALTH's REPORT DATED MARCH 27, 2009

CLICK HERE FOR MENTAL HEALTH's REPORT DATED JUNE 30, 2009

CLICK HERE FOR MENTAL HEALTH's REPORT DATE SEPTEMBER 30, 2009

CLICK HERE FOR CEO's REPORT DATED FEBRUARY 1, 2010

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CLICK HERE FOR CEO's REPORT DATED JULY 1, 2010

CLICK HERE FOR CEO's REPORT DATED SEPTEMBER 30, 2010

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COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: Olivia Celis-Kanm
Phone #: (213) 738-2147

March 27, 2009

TO: Each Supervisor

FROM: Marvin J. Southard, D.S.W.
Director of Mental Health

Patricia S. Ploehn, L.C.S.W.
Director of Children and Family Services

SUBJECT: **KATIE A. IMPLEMENTATION PLAN**

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003)
- Enhanced Specialized Foster Care Mental Health Services Plan (2005)
- Findings of Fact and Conclusions of Law Order, 2006, issued by Federal District Court Judge Howard Matz
- Health Management Associates Report (2007)
- Katie A. Corrective Action Plan (2007)

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

- Mental health screening and assessment
- Mental health service delivery
- Funding of services
- Training

- Caseload reduction
- Data/tracking of indicators
- Exit criteria and formal monitoring plan

The Strategic Plan also provides that the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS) would inform your Board of any revisions to the implementation of the Strategic Plan by March 2009, and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan, this report will also describe any significant deviations from the planning described in those documents. Please refer to Attachment A which includes the Katie A. Implementation Plan Project Data Sheets (PDSs) for more detailed information.

Status of October 14, 2008 Board Letter Recommendations

- Recommendation 1 – The conceptual framework of the Katie A. five-year Strategic Plan has been approved by the Board, Katie A. Advisory Panel, and Plaintiffs' attorneys. The Federal Court overseeing the Katie A. Settlement Agreement will receive a copy of this memo along with the detailed implementation PDSs for formal approval in May 2009.

- Recommendation 2 – Of the $7.1 million appropriation adjustment transferred into Provisional Financial Uses (PFU) to offset Fiscal Year (FY) 2008-09 costs only $1.1 million remains. We propose transferring any FY 2008-09 savings, identified at the close of the fiscal year, into another PFU to offset program costs in FY 2009-10.

- Recommendation 3 – DCFS was approved to fill 61 positions by the end of FY 2008-09. As of today, 24 of the 44 positions, identified for mental health screening and assessment and training purposes, to be filled by March, have been hired; 17 positions have been hired pending release; and 3 positions are pending selection. The remaining 17 positions to support mental health service delivery functions are slated to be hired between April and June 30, 2009.

- Recommendation 4 – DMH received formal notification from the Chief Executive Office (CEO) in mid-December of 2008 of the allocation of the three DMH items described in the Strategic Plan for FY 2008-09. DMH has hired one of the three positions, and has initiated the hiring process for the second item. DMH continues to work with the CEO regarding the appropriate level of the third item requested and will work to fill the position as soon as possible.

- Recommendations 5 and 6 – The directors of DMH and DCFS received delegated authority to develop and execute contracts with mental health and training contractors to provide mental health/training related services proposed in the Strategic Plan, contingent upon funding availability. Contract amendments are currently being prepared by DMH and DCFS for Wraparound and Full-Service Partnership (FSP) providers to deliver the Wraparound/Child Family Team (CFT) service delivery provision detailed in the Strategic Plan and attached Wraparound PDS. Additional information on the status of training efforts is described later in this memo under "Training."

- Recommendation 7 – The CEO was directed to develop and pursue legislative, regulatory, and administrative proposals seeking to maximize revenue reimbursement from the state, particularly for Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds. As discussed in the Legislative Advocacy PDS, the CEO has been working closely with County Counsel and the departments, and a policy proposal has been drafted by County Counsel examining whether a Medi-Cal State Plan amendment is required to issue higher reimbursement rates to mental health providers delivering specialty mental health services to children in Wraparound programs as part of the Medi-Cal Schedule of Maximum Allowances. More detail on how to implement a higher reimbursement rate structure will be developed in the coming months.

- Recommendation 8 – DCFS and DMH conducted an all-day joint Learning Organization Group (LOG) on the Katie A. Strategic Plan on December 1, 2008 for regional management and program staff which was attended by 238 individuals. The conference was well-received and based on a five-point Likert Scale with (1) being very poor and (5) very good, the average ratings for the seven topical assessment areas measuring conference effectiveness averaged 4.11 or higher. DCFS and DMH program managers have subsequently been conducting meetings on a weekly basis with regional staff at the various offices to pick up where the LOG left off regarding barriers to implementation, departmental roles and responsibilities, and to prepare offices for the future rollout of the Katie A. Strategic Plan. To date, 12 meetings have been conducted with the regional offices, and the office visits are expected to conclude in early May 2009.

- Recommendation 9 – The Departments have been directed to conduct annual assessments beginning in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement. In the interim, quarterly reports will be submitted on implementation activities by June 30, 2009 and September 30, 2009.

Status of Implementation of Strategic Plan Provisions

Mental Health Screening and Assessment

The Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health services. A number of programs have been developed to facilitate this process, which are described in greater detail in the following nine PDSs: 1) Medical Hubs; 2) Coordinated Services Action Team (CSAT); 3) Multidisciplinary Assessment Team (MAT); 4) Referral Tracking System (RTS); 5) Consent; 6) Benefits Establishment; 7) D-Rate; 8) Team Decision-Making (TDM) and Resource Management Process (RMP); and 9) Specialized Foster Care.

We are pleased to report that significant progress has been made by each of these project teams. By effectively managing the hiring process in coordination with the development of policy, training, and a data tracking system, the Departments are on schedule to meet the goals of systematically screening and assessing children. For example, the Departments have developed a process by which Katie A. related documents can be reviewed across department lines and issued concurrently. In particular, much progress has been made related to the completion and documentation of the Mental Health Screening Tool (MHST); the complicated issues of consent for mental health services and the authorization of release of mental health records; identifying crucial data fields for the Referral Tracking System (RTS), which when developed, will enable CSAT staff to track and provide reliable data through an automated system; an improved Psychotropic Medication Authorization (PMA) process managed through the D-Rate Program; clarification of the respective roles of the DCFS and DMH staff in the Resource Management Process; and the roles and responsibilities of the co-located DMH staff housed in DCFS regional offices.

Two screening and assessment components vary from the Strategic Plan. The Strategic Plan describes the rollout of the CSAT to begin (Phase One) according to the following schedule in the selected offices:

- SPA 7 – Belvedere and Santa Fe Springs were trained in March 2009
- SPA 6 – Wateridge and Vermont Corridor offices will be trained in April 2009
- SPA 6 – Compton will be trained in May 2009
- SPA 1 – Palmdale and Lancaster will be trained in June 2009

The rollout schedule has been changed slightly to allow for greater opportunities to learn from the experience of the SPA 7 implementation. The SPA 7 schedule will remain as is; however, the schedule for the following offices has been revised as follows:

- SPA 6 – Wateridge and Vermont Corridor offices will be trained in May 2009
- SPA 6 – Compton will be trained in June 2009

- SPA 1 – Palmdale and Lancaster will be trained in July 2009

Program implementation will commence the month following staff training.

Additionally, as noted in the Corrective Action Plan, and reiterated in the last update to the Board in June 2008, the Countywide expansion of the MAT program was anticipated to be rolled out in SPAs 1 and 7 by February 2009 and in the remaining SPAs by June 2009. In SPAs 1 and 7, providers have been identified, contracts amended, and training completed and referrals are beginning to be made to these agencies. In SPAs 2, 4, and 8, MAT providers have been identified and DMH is in the process of amending contracts and scheduling training for these new MAT providers. It is expected that these three SPAs will be able to implement MAT by the end of this fiscal year, with only SPA 5, with a projected implementation timeline of first quarter of FY 2009-10, behind the original projected timeline.

As depicted in Attachment B, the number of referrals to the MAT program has more than tripled in the last three years since program inception. This increase in program efficiency is directly attributable to the hiring of DCFS and DMH MAT Coordinators in SPAs 6 and 3, where the MAT program was already in place. Note that the data reported in Attachment B for FY 2008-09 is only for the first six months of the fiscal year and that if we extrapolate this figure over the entire fiscal year the total number of MAT referrals for the current fiscal year would, conservatively, double from the number reported here to over 1,800 referrals.

Mental Health Service Delivery

The Mental Health Service Delivery section of the Strategic Plan describes an expansion of the existing Wraparound program by 2,800 additional slots, to be accomplished over the course of the next five years, using a three-tiered model with tiers ranging in intensity of service based upon the child's needs. Tier One represented the current Wraparound Program and was described as being the appropriate choice for those children with the most intensive service needs; while Tier Two, funded with a case rate and EPSDT allotment, was for those children with less intensive service needs; and Tier Three, funded with Mental Health Services Act (MHSA) FSP funds as well as a monthly case rate, was described as the appropriate service level for children with the least intensive service needs. The plan described that children would be placed in one of these Wraparound/Child and Family Team (CFT) tiers based upon service need and children would be able to transition up or down from one tier to another, while maintaining the same treatment team based on changing service needs.

The three-tiered model described in the Strategic Plan has been revised to a two-tiered model as implementation of the model revealed programmatic similarity between Tier Two and Tier Three populations and unnecessary complexity of a three-tiered model. Tier One remains the same at 1,400 slots and represents the existing Wraparound Program for

children whose emotional/behavioral problems threaten placement or have resulted in an RCL 10 or above placement. Tiers Two and Three have been combined into one service level for children who do not meet the eligibility criteria for Wraparound, but present a need for intensive mental health services. The 2,800 slots consist of 2,051 DCFS created slots and 749, comprised of 523 Child plus 226 Transition Age Youth (TAY) FSP slots. (Please see the attached Wraparound PDS for more detail). A decision was made to eliminate the characterization of the tiers as targeted to children with different needs for intensive services, understanding that the assessment of service need may change quickly and repeatedly, creating an unnecessarily complicated transition between tiers. These programmatic revisions have resulted in modifications to the case rate and associated ESPDT funding for the two-tiered model (as described in the Finance PDS), which DOES NOT exceed the total funding requested or allocated in the October 2008 Board letter. The funding distributions for the tiers have been revised as follows:

- Tier One - the case rate for the 1,400 slots will remain at $4,184 per month, inclusive of placement costs, but the EPSDT monthly allocation has been enhanced to $2,246 per month. The costs for the $0.7 million net County cost (NCC) increase in Tier One required EPSDT County match are fully funded within the Strategic Plan funding approved by your Board.

- Tier Two - the case rate for both the DCFS generated and DMH FSP slots has been changed to $1,250 per month, exclusive of placement costs, and with the same monthly EPSDT allocation $2,246 as Tier One. The total yearly cost for these 2,800 slots is $117,466,000 of which $43,779,000 will be derived from NCC when fully implemented.

The simplification from a three-tiered to a two-tiered model will make the administration of the model more manageable. The redistribution of funds across the two tiers makes the two-tiered service provision more equivalent, which will enable service providers to deliver whatever service intensity is required under the "Do Whatever it Takes" model for providing Wraparound, regardless of what tier a child was initially placed in. This approach also recognizes the provider practice of pooling the EPSDT allocations, regardless of tier allocation, in order to meet the needs of individual clients. Attachment C describes the types of behavioral issues a child may present to be placed in a tier one or tier two slot and the related services provided by the respective tiers in addressing the child's needs.

The timeline for the Tier Two rollout will begin in May 2009 with the provision of 25 DCFS slots per month. The Tier Two FSP slots will be available beginning in July 2009, at which time, the rollout formula will include a total of 75 slots per month comprised of 50 Tier Two FSPs and 25 DCFS generated slots.

Another intensive mental health service program, originally discussed in the Corrective Action Plan, where planned rollout of services has been slower than expected, is the

County's Treatment Foster Care (TFC) program. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge Howard Matz, the County was directed to develop 300 treatment foster care beds by January 2008. Presently, the County has contracted for 152 beds, but only 27 treatment foster care homes have been certified and currently only 16 children are placed in these homes.

As described in the TFC PDS, efforts to comply with the court order to develop 300 foster care beds are well underway; however, progress toward the realization of the full program will likely continue to be slow, but steady, for the following programmatic reasons, including: 1) the difficulty in the recruitment and development of foster home placements; 2) the lengthy matching process between the child and foster home; 3) the required additional foster parent training of 40 hours above foster family agency certification requirements; 4) delay in receipt of livescan clearances of foster parents; 5) the required completion of adoption home studies of resource parents prior to placement; 6) lead time needed to build awareness of program with line staff and other program staff to generate referrals; and 7) the unavailability of sufficient numbers of permanency partners for Multidimensional Treatment Foster Care placements in SPA 6. The Court-appointed Katie A. Advisory Panel is well aware of the County's difficulties in bringing up these slots. The Panel has been briefed throughout 2008 and most recently in February 2009 of the ongoing challenges. We will continue to keep the Board apprised of our efforts to expand the number of TFC slots.

Funding of Services

All three Departments are closely monitoring expenditures this fiscal year and anticipate some savings for FY 2008-09. More information will be available on the anticipated savings at year-end closing. Any savings resulting from the amended implementation rollout schedules discussed above will be requested to be transferred into PFU to offset FY 2009-10 costs. Plaintiffs' attorneys' costs and anticipated duration of services, along with those of the Katie A. Panel, will be forwarded under separate cover from County Counsel as a confidential attorney client communication. We propose to use FY 2008-09 savings to cover these costs now and in future years.

As discussed in the October 2008 Board letter, it's important to note that proposed cost projections may change over the years, based on changes in foster care caseloads, implementation of prevention related activities, such as the DMH led Prevention and Early Intervention (PEI) initiative, as well as the DCFS Prevention Initiative Demonstration Program (PIDP), which in concurrence with the innovative reforms supported by the Title IV-E Waiver may help deflect new cases from entering the child welfare system. As depicted in Attachment D, the number of DCFS involved children served by DMH continues to grow, even as the total caseload of DCFS decreases.

Additionally, the expenditures related to mental health services for DCFS involved children (Attachment E) continue to increase each year. The effective utilization of the EPSDT revenue stream, in addition to the Federal Economic Stimulus Package's augmented Federal Medical Assistance Percentage (FMAP), will provide some temporary fiscal relief to the County, which can be used to offset some of the service expansion costs for Katie A. class members in FYs 2009-10 and 2010-11.

Training

DMH and DCFS have worked closely together to develop a number of necessary training components relating to the Strategic Plan, including:

- a joint overview/orientation for DCFS, DMH, and contract provider staff, training to support targeted strategies (such as TDM, Structured Decision Making (SDM), concurrent planning re-design, visitation, etc.) to support the caseload reduction efforts for DCFS
- specialized training in support of the newly developed policies and practice guidelines
- specialized training for newly hired staff
- provider training to support the expansion of Wraparound
- the core practice model to support the QSR elements
- coaching and mentoring approaches to improve practice
- the development of a sophisticated tracking system to document and report on trainings, as detailed in the Training PDS

Training contracts to support the Wraparound/CFT service provision, along with the expectations of the Core Practice Model and Quality Services Review (QSR), will be operational in May 2009 prior to the rollout of the Wraparound/CFT service provision.

Training activities are on schedule to support the rollout of these various activities.

Caseload Reduction

The Strategic Plan outlines a number of initiatives to be undertaken by DCFS in support of the Department's strong interest in reducing the caseloads of Children's Social Workers (CSWs). We are pleased to note that progress toward the goals described in the Strategic Plan has been made. Reductions have been made in both the screen in rate and the immediate response referral rate. The total number of children in Permanent Placement (PP) has been reduced by over one thousand. Generic caseloads have been reduced from an average of 26 children per worker to 23 children per worker, while the Emergency Response (ER) caseload has been reduced from an average of 24 children per worker to 19 children per worker.

DCFS has also made significant strides in hiring new CSWs, with 289 new CSWs hired from June through December of 2008, exceeding the goal of 160 new hires described in the Strategic Plan. As of February 2009, the CSW vacancy rate is only at three percent.

Data/Tracking of Indicators

DMH and DCFS continue to work toward hiring the staff to support the development of an electronic system for tracking and reporting of data indicators. DMH has hired two of the three DMH Chief Information Office Bureau (CIOB) positions approved through the Corrective Action Plan, and the CEO and Department of Human Resources (DHR) are providing support for recruitment of the third position. DCFS has selected staff for four of the five IT positions requested in the Strategic Plan.

The Referral Tracking System described in the Strategic Plan will require systems development from both DCFS and DMH in order to automate, streamline, and track the process of screening and referral. Approximately $500,000 from the Strategic Plan has been allocated to DMH to hire consultants to act as Project Manager, Business Analyst, and Applications Developer to provide support in developing the Katie A. database and associated cubes, and DMH has drafted a Statement of Work to support the solicitation of these consultants. We anticipate these contract staff to be available by August 2009.

DMH and DCFS, in conjunction with the Katie A. Advisory Panel, County Counsel, and plaintiffs' attorneys, are finalizing a discrete set of data indicators (as described in the Data PDS and attached Katie A. Data Inventory) that will be tracked as either formal exit criteria or contextual information as one of three prongs, described below in "Exit Criteria" for monitoring compliance with the Settlement Agreement.

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the successful adoption by the Board of Supervisors of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators and a passing score on the QSR measure.

We plan to present the Strategic Plan, with the modifications discussed in this status report, for approval by the Court in May 2009. At this time, we anticipate that the Strategic Plan and accompanying Implementation Memo and PDS will be approved by the Court.

The departments will begin to track quarterly, the attached data indicators manually, to the extent possible, until a more sophisticated application and database can be developed as described above.

The QSR process is planned to take place in three phases, described in the attached QSR PDS. Phase One calls for the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan. These activities are expected to be completed between July 2009 and July 2010.

Phase Two, to be completed between September 2010 and December 2012, commences the administration of the QSR across the 18 DCFS Regional Offices; while Phase Three, to be completed by December 2013, consists of any follow up reviews that might be necessary to achieve passing scores.

DCFS has hired a Children's Services Administrator II (CSA) to head a new Quality Improvement Section that will have lead responsibility in implementation of the QSR process. Now that staff is in place, the QSR protocol will be detailed in the coming months including the proposed sample size, percent standard for achieving a passing score, and criteria for exiting the review process.

Summary

The implementation of the Katie A. Strategic Plan is being fully executed by the Departments and progress has been made toward achievement of the Settlement Agreement objectives. The Strategic Plan has been organized into eighteen project teams, each having sponsors, managers, team members and Project Data Sheets that are updated monthly to summarize the objectives, outcomes, deliverables, resources, dependencies, risks and benefits. The Departments' steadfast oversight and collaboration are evident and rapidly moving the County toward resolution of its obligation. Quarterly reports will be provided to your Board.

Please let us know if you have any questions regarding the information contained in this report, or your staff may contact Olivia Celis-Karim, DMH Deputy Director, at (213) 738-2417 or ocelis@dmh.lacounty.gov .

MJS:OC:GL:nr

Attachments (A - E)

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

Attachment A

Attachment A1

County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #1- Implementation Planning	
Start Date: October 14, 2008	
Sponsors: Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
Project Managers: Adrienne Olson, DCFS Greg Lecklitner, DMH	
Background: In 2008, the Los Angeles County (County) Departments of Children and Family Services (DCFS) and Mental Health (DMH) developed and received approval of the Katie A. Strategic Plan which provided a detailed plan for the implementation/delivery of mental health services over a five-year period to fulfill the objectives of the July 2003 Katie A. Settlement Agreement. The Departments have been charged to return to the Board of Supervisors in March 2009 with a detailed implementation plan. Focus will be to provide oversight and technical support, monitor and report back on the development and successful execution of 17 projects that, collectively, will fulfill the objectives outlined in the Katie A. settlement Agreement.	
Project Objective:	**Expected Operational Date:**
1. Insure successful realization, ongoing oversight and monitoring, and reporting on all activities outlined in the Katie A. Strategic Plan.	10/14/08 – 10/14/11
2. Oversee and monitor the implementation and institutionalization of the activities outlined in the Katie A. Strategic Plan by overseeing the development of the infrastructure that will support ongoing provision of mental health services to children in the child welfare system.	10/14/08 – 10/14/11
Expected Outcomes: Ensure that all class members (as defined in the Katie A. Strategic Plan): 1. Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs; 2. Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;	

3. Be afforded stability in their placements, whenever possible; and 4. Receive care and services consistent with good child welfare and mental health practice and the requirements of the law.			
Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Monitor, provide oversight and report on the status of eighteen (18) projects that comprise the Katie A. Implementation Plan.	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	In progress. The goal is to exit oversight in 2011.
2. Monitor and provide oversight of the hiring of staff to insure that all allocated Katie A. positions are filled.	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	In progress- weekly updates provided.
3. Conduct Katie A. Learning Organization Group event to bring together DCFS, DMH, CEO and experts to provide information on the strategic plan and receive feedback on the Katie A. Strategic/Implementation Plan	Adrienne Olson Greg Lecklitner	10/14/08 – 12/1/08	Completed 12/1/08
4. Provide the DCFS Executive Committee and Regional Administrators with electronic weekly Katie A. updates on implementation.	Adrienne Olson Greg Lecklitner	10/14/08 – 2/1/08	In progress and on-going
5. Develop and maintain Katie A. internal DCFS/DMH websites.	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	Completed 2008 Maintenance is on-going
6. Develop and maintain Katie A. web page on the external DCFS website.	Adrienne Olson	10/14/08 – 10/14/11	In progress
7. Develop and maintain a blog on the internal Katie A. websites.	Adrienne Olson	10/14/08 – 10/14/11	Pending, expected to go live 7/1/09
8. Conduct weekly Regional Office visits that provide the background of the Katie A. lawsuit, an overview of the strategic plan, provide a forum to receive input on local implementation.	Dr. Charles Sophy Adrienne Olson Olivia Celis-Karim Greg Lecklitner	SPAs 1, 3, 6, 7 completed by 3/10/09. SPAs 2, 4, 5, 8, Adoptions and	In progress

		the Medical Placement Units to be completed by 5/5/09.	
9. Develop, coordinate and deliver other strategies to communicate and effectively engage all other key stakeholders, such as the court, caregivers, providers, commissions and unions, in the process of implementing the eighteen Katie A. projects.	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	In progress
10. Coordinate monthly Executive Leadership Meeting: DCFS, DMH, County Counsel and CEO executive level management meet and receive status updates to ensure that a holistic and integrated vision are developed to provide mental health services to children in the child welfare system.	Miguel Santana Sheila Shima	10/14/08 – 10/14/11	In progress and on-going
10. Coordinate meetings with Board Deputies as needed between DCFS, DMH, County Counsel and CEO to provide Katie A. updates to the Board Deputies through discussions of key strategic plan policy decisions made by the Departments' Executive Leadership and then obtain Board Deputy feedback.	Miguel Santana Sheila Shima	10/14/08 – 10/14/11	In progress and on-going
11. Coordinate monthly Departmental Leadership Meeting: DCFS, DMH, County Counsel and CEO Katie A. management leads discuss and resolve legal, policy, program, and financial issues.	Lesley Blacher	10/14/08 – 10/14/11	In progress and on-going
12. Coordinate semi-monthly Project Leadership Conference Call: DCFS, DMH, County Counsel and CEO management leads share critical information and develop next steps with the Advisory Panel and Plaintiff's Attorney.	Lesley Blacher	10/14/08 – 10/14/11	In progress and on-going
13. Coordinate quarterly Panel Retreat: DCFS, DMH County Counsel and CEO executive level and management	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	In progress and on-going

leads are to discuss and receive input on legal, policy, program and financial issues with the Advisory Panel and Plaintiff's Attorney.	Lesley Blacher		
14. Coordinate weekly CHAMPS Group: DCFS, DMH, DHS, DPO, and CEO Managers coordinate implementation across departments.	Dr. Charles Sophy Olivia Celis-Karim	10/14/08 – 10/14/11	In progress and on-going
15. Coordinate monthly Joint Operational Planning meeting for DMH central and regional management providing high-level progress reports and receiving feedback for Katie A. workgroups to inform implementation planning.	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	In progress and on-going
16. Prepare all required reports and memoranda to inform the Board of Supervisors on the status of the implementation of the Katie A. Strategic Plan.	Adrienne Olson Greg Lecklitner Lesley Blacher	10/14/08 – 10/14/11	In progress and on-going
17. Provide the Advisory Panel with a quarterly Katie A. tracking report. DCFS, DMH, County Counsel and CEO Katie A. management leads provide updates on the status of the implementation of the Katie A. Settlement Agreement in LA County.	Elaine Magnante-Music Gary Puckett	10/14/08 – 10/14/11	In progress and on-going

Resources:

1. DCFS Katie A. Administration staff consists of seven (7) full time staff: one (1) Division Chief, three (3) managers, and three (3) support staff, to oversee the 18 project that encompass the Katie A. Implementation Plan.
2. DMH has four (4) staff: two (2) District Chiefs and two (2) Program Heads to oversee the 18 projects that encompass the Katie A. Implementation Plan.
3. The CEO has identified two (2) full time staff to oversee the 18 projects that encompass the Katie A. Implementation Plan.

Dependencies:

1. All Katie A. DCFS and DMH staff vacancies are filled as scheduled.
2. Providers must have sufficient capacity to provide services for referred children and families.
3. Successfully communicate the plan and engage all stakeholders to support implementation.
4. Successful management of the seventeen other projects that make up the Implementation Plan.

Customer Benefits:

1. The County will exit oversight by the federal court.

2. Seamless integration and provision of an array of mental health services that are culturally sensitive, tailored to individual needs and fiscally responsible.
3. Children's Social Workers will receive expert assistance from CSAT and spend less time searching for and linking clients to services.
4. Support the Departments objectives to increase safety, reduce time spent in foster care and reduce timelines to permanence.

Issues and Risks:

1. Failure to successfully engage stakeholders.
2. Appointment of Special Master by the court.
3. Identification of sufficient qualified staff.

PROJECT TEAM MEMBERS

Name/Organization	Phone	E-Mail
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Lesley Blacher, CEO	(213) 974-4603	Lblacher@ceo.lacounty.gov
Rigo Rodriguez	(714) 504-7446	rigoberto@sbcglobal.net
Dr. Charles Sophy, DCFS	(213) 351-5614	sophyc@dcfs.lacounty.gov
Adrienne Olson, DCFS	(213) 351-5737	olsona@dcfs.lacounty.gov
Olivia Celis-Karim, DMH	(213) 738-2147	Ocelis@dmh.lacounty.gov
Greg Lecklitner, DMH	(213) 739-5466	Glecklitner@dmh.lacounty.gov

County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #2**-** Medical Hubs	
Start Date: 2006	
Sponsors: Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director Cheri Todoroff, DHS	
Project Managers: Donna Fernandez, DCFS Janel Jones, DMH Karen Bernstein, DHS	
Background: A countywide Medical Hub Program (Hub) has been established to provide expert medical examinations, including forensic evaluations, and care to newly detained DCFS children. The Hub ensures that children at high risk for health and mental health problems receive a thorough and comprehensive initial medical examination, including age-appropriate developmental and mental health screenings, and a forensic evaluation, if deemed appropriate, when there is an allegation of physical or sexual abuse. Hub physicians are experts in detecting and treating child abuse and neglect.	
Project Objective:	**Project Objective:**
1. Increase the number of newly detained children seen at the Hubs. As of November 2008, based on DCFS data and Hub data, 64% of newly detained children received an Initial Medical Exam at a Hub. The goal is to increase the percentage to 100% of newly detained children placed within Los Angeles County.	6/30/10
2. Integration of California Institute Mental Health (CIMH) screen results into DCFS/DMH service delivery systems will ensure delivery of mental health assessments and treatment for newly detained DCFS served children.	To be coordinated with implementation of CSAT as follows: SPA 7: 5/15/09 SPA 6: 6/1/09 – 7/1/09 SPA 1: 8/1/09

Expected Outcomes:

1. DCFS served, newly detained children will receive comprehensive medical exams, including forensic evaluations, as determined needed, and age-appropriate mental health screens that addresses children's specific needs.
2. DCFS newly detained children will receive mental health assessments and appropriate treatment to meet their specific needs.
3. The health information from the Hubs will be integrated into MAT assessment document and statement of findings.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Implement monthly tracking of the number of children receiving an initial medical examination at a medical Hub compared to the number of newly detained children.	Donna Fernandez Karen Bernstein	Ongoing	Complete
2. Implement revised Hub policy that re-emphasizes all newly placed court involved children in out-of-home care are seen at a Hub for initial medical examinations and age-appropriate mental health screens.	Donna Fernandez	5/1/09	In progress
3. Implement a Violence Intervention Program (VIP) satellite Hub at the former MacLaren Children's Center in El Monte to serve the eastern portion of Los Angeles County.	Karen Bernstein Donna Fernandez	4/1/09 – 5/30/09	In progress Renovations finished. Furniture/ equipment obtained and staffing identified. Awaiting installation of data and telephone lines.
4. Improve efficiency and coordination of care through implementation of E-mHub across the DHS Hubs.	Karen Bernstein Donna Fernandez	5/31/10	In progress Workgroup is meeting weekly, negotiations underway with vendor. Contract approval by Board of Supervisors (BOS) targeted for 5/19/09.

5. Continue to address opportunities to improve space required for the completion of examinations at Olive View UCLA Medical Center Hub.	Karen Bernstein	Ongoing	In progress Olive View Medical Center capital project, including expanded space for the Hub, to be complete FY 09-10.
6. Track referrals to the Hub and to the MAT providers in each regional office at the point of detention.	Laura Andrade	1/2/09 – 7/31/09	SPA 3 & 6: Complete SPAs 1 & 7: 7/31/09
7. Implement a DCFS/ Hub Workflow Process.	Donna Fernandez Karen Bernstein	Completed	In progress DCFS, DHS and DMH continue to work closely with the Hubs and DCFS offices to ensure smooth operations and troubleshoot as required.
8. Implement DMH CIMH follow-up procedures for the co-located units and track results in each office.	Janel Jones	Completed	In progress Integrating with DCFS/DMH referral and tracking system compliance in all DMH co-located sites.

Resources:

1. DCFS Program Manager of Health, Mental Health and Substance Abuse Services and two (2) staff have direct oversight of the Medical Hub Program.
2. DHS Special Programs Director and Medical Hubs Coordinator are responsible for the Medical Hubs Program across DHS facilities, supported by the Planning and Program Oversight Deputy.
3. Hub Medical Directors and Program Administrators, DCFS, and DMH staff meet monthly to coordinate issues across the Hubs and between departments.
4. DMH Program Manager in the Child Welfare Division (CWD) serves part time as a liaison to the Hub, communicating the objectives and deliverables to the various managers within the CWD and the DMH Specialized Foster Care co-located sites.

Dependencies:

1. Allocation in FY 2009-2010 budget for two (2) additional out-stationed CSW IIIs to serve as after hours liaisons at the VIP Hub to meet the needs of ERCP.
2. Immediate DCFS internal approval of revised DCFS Hub policy.
3. Implement VIP satellite Hub immediately.
4. Timeline for implementation of E-mHub is dependent upon CEO, County Counsel, and BOS approval of the contract.
5. Implement CSAT pilot in SPA 7 by 5/1/09 and roll out in SPA 6 by 6/1/09 and SPA 1 by 8/1/09.

Customer Benefits:

1. Newly detained children will have their medical and emotional needs addressed by experts in a timely manner.
2. Health and mental assessment information will be integrated to assist in developing the child's case plan.
3. Each assessment and intentions will reduce time in out-of-home care and will increase permanency.

Issues and Risks:

1. DCFS FY 09/10 budget constraints can affect hiring of two (2) additional CSW IIIs to serve the VIP Hub after hours.
2. The rollout of several large initiatives across all eight (8) SPAs will be a challenge as integration of these various programs, (MAT, Hubs, co-location of DMH staff, CSAT, referral tracking system, etc.), requires ongoing support and commitment from leadership at the County level, SPA level and across all Departments.

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Attachment A3

County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #3- Coordinated Services Action Team (CSAT)	
Start Date: April 1, 2009	
Sponsors: Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
Project Managers: Janel Jones, DMH Jacqueline Wilcoxen, DMH Roberta Medina, DCFS Lisa Sorensen, DCFS	
Background: The development of CSAT is a result of the Health Management Association's 2007 report on the relation of the implementation of the Enhanced Specialized Foster Care Mental Health Services Plan and lack of a coordinated vision guiding the systematic mental health screening, assessment, and receipt of appropriate services. CSAT seeks to coordinate, structure, and streamline existing programs and resources to expedite mental health assessments and service linkage when a positive mental health screen or mental heath trigger has been presented. While CSAT originated in the Katie A. planning process, it encourages fundamental change, beyond mental health service access and utilization, to incorporate every aspect of DCFS service delivery by simplifying service referrals/linkages for social workers. Lack of a centralized referral management structure limits the Department's ability to track service capacity, utilization rates and trends, and to make rapid adjustments as needed.	
Project Objective:	**Expected Operational Date:**
1. Create and implement CSAT teams in SPAs 1, 6 & 7 and ensure that every child on an open DCFS case in those SPAs receives a Mental Health Screening Test, is assessed if the results of the MHST are positive, referred to treatment and linked to services if necessary. For children who are in need of mental health services but have no benefits, efforts will be made to seek supportive services and to establish benefits when possible	SPAs 1, 6 &7 – 8/1/10 SPAs 2, 3, 4, 5 & 8 - 6/1/11
Expected Outcomes: 1. Maximum utilization of existing and future resources and programs.	

2. Increased ability of DCFS and DMH to rapidly and accurately identify the needs of the DCFS population, and deploy resources and services as necessary.
3. Existing support staff will combine with newly hired staff to create teams that will assist with systems navigation to quickly identify the most appropriate available services for which an individual child and/or family is eligible.
4. Reduced workloads for CSWs because of simplified forms, reduced numbers of case presentations and easier service authorization.
5. Easier access for CSWs to co-located support staff.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Visit each Regional Office to explain CSAT and receive feedback regarding local strengths, needs and concerns.	Dr. Charles Sophy Adrienne Olson Olivia Celis-Karim Greg Lecklitner	1/13/09- 5/5/09 Visit one office per week until all 18 offices are completed.	Weekly office visits began 1/13/09 and will continue until 5/5/09. 13 offices complete: 1/13/09 - 3/31/09 5 offices pending: 4/1/09- 5/5/09
2. Develop CSAT policy for DCFS and DMH.	Guy Trimarchi Lisa Sorensen Greg Lecklitner John Coyle	7/1/08 – 3/1/09	Final draft complete, minor changes.
3. Hire Service Linkage Specialists for SPAs 1, 6 &7.	Roberta Spears-Mathews	10/14/08 – 3/1/09	Completed
4. Develop training for CSAT members and Regional Office staff	Mark Miller Angela Shields	10/1/08 – 3/1/09	In progress
5. Complete training for regional staff and CSAT members for individual Regional Offices.	Mark Miller Angela Shields	See Training PDS for timeline	In progress
6. Begin CSAT process in each Regional Office in SPAs 1, 6 & 7.	Lisa Sorensen Roberta Spears-Mathews	Directly after training completed	Pending
7. Review data to track effectiveness of CSAT in each office, identify barriers to greater efficiency to ensure	Lisa Sorensen	Starting 5/1/09	Pending

the ongoing timely screening, assessment, linkage and delivery of mental health services. Make adjustments within each CSAT as needed.			
8. Hire Service Linkage Specialists for SPAs 3, 4, 5 & 8	Roberta Spears-Mathews	7/1/09 – 1/1/10	Pending
9. Develop training for CSAT members and Regional Office staff for SPAs 3, 4, 5 & 8	Mark Miller Angela Shields	See PDS for Training for timeline	In progress
10. Complete training for regional staff and CSAT members for individual Regional Offices in SPAs 3, 4, 5 & 8	Mark Miller Angela Shields	Directly after training	Pending
11. Begin CSAT process in each Regional Office in SPAs 3, 4, 5, 8	Lisa Sorensen Roberta Spears-Mathews	Sta. Clarita/ SFV- Pomona/Glendora- Metro North- West Los Angeles- Torrance/ So. County-	Pending
12. Review data to track effectiveness of CSAT in each office, identify barriers to greater efficiency to ensure the ongoing timely screening, assessment, linkage and delivery of mental health services. Make adjustments within each CSAT as needed.	Lisa Sorensen	Starting 1/1/10	Pending

Resources:

1. DCFS CSA III will manage DCFS CSAT staff.
2. SLS CSA II, 7 SLS CSA Is, MAT CSA II, 7 MAT CSA Is, D-rate CSA II, 2 D-rate Evaluator SCSWs, 7 D-rate Clinical Evaluator CSW IIIs (26 professional staff) and 9 clerks to manage the intake of Mental Health Screening Tools, MAT assessments, D-rate re-evaluations and benefit establishment for all children.
3. DMH co-located staff in each office to provide consultation, assessment, and crisis intervention and service linkage.
4. Data tracking system (in development) to provide tracking tools for each Regional Office.

Dependencies:

1. Timely completion of polices/guidelines for Consent, Benefits and Data Tracking to ensure adequate training, reliable data tracking, ability to procure and secure benefits, and timely linkage to service providers based on preauthorized consent and release of information.
2. Support by line staff to receive timely mental health screenings, and to assist and consult with CSAT members to ensure strong

engagement between children, caregivers and mental health providers.
3. Adequate office space to house additional staff.
4. Continued reduction and stabilization of caseloads to afford CSWs the opportunity for increased teaming.

Customer Benefits:
1. CSWs will receive additional support in screening, assessing and linking children to services.
2. CSWs will be able to use time spent identifying and procuring services for families to provide direct services.
3. Service providers will have better access (through CSAT members) to real time data to plan their service array and make informed decisions regarding the number of slots allocated for DCFS children.
4. Expedited linkage to and engagement with mental health service providers due to support CSWs will receive obtaining consent, authorization for release of information and benefits establishments.
5. All children in open cases will be promptly and routinely screened for mental health needs.

Issues and Risks:
1. Resistance of staff to change with perception of additional work load.
2. Continued space limitations in DCFS Regional offices present logistical challenges for CSAT members.
3. County and State budget crisis could cause adverse affects on mental health services for children.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #4- Multidisciplinary Assessment Teams (MAT)	
Start Date: June 1, 2005	
Sponsors: Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director	
Project Managers: Laura Andrade, DCFS Gary Puckett, DMH	
Background: The Multidisciplinary Assessment Team (MAT) Program began in June 2005 in Service Planning Area (SPA 6) offices and expanded to SPA 3 in October, 2005 and has been operational in these two SPAs for more than three years. The purpose of MAT is to provide a comprehensive assessment of each child's and family needs as a child enters foster care. MAT Teams will continue to be rolled out to all SPAs and SPAs 1 and 7 will be ready in February 2009. The remaining SPAs (2, 4, 5, and 8) are due to become operational as DMH contracted provider agencies are identified and contracts are signed, and will be county-wide in the first quarter of FY 2010.	
Project Objective:	**Expected Operational Date:**
1. Maintain the timely delivery of MAT assessments in currently operational SPAs (3 and 6).	1/1/09 and ongoing
2. Begin MAT implementation in SPAs 1 and 7 by February 2009	2/28/09
3. Complete MAT implementation in SPAs 2, 4, 5, 8 by June 2009	6/30/09
Expected Outcomes: 1. Children that receive MAT assessments have shorter stays in out-of-home care than those who do not receive MAT assessments. 2. Children that receive MAT assessments have greater placement stability than those who do not receive MAT assessments. 3. Children that receive MAT assessments will be linked to needed services faster.	

Deliverables:	Project Lead(s):	Planned Timeline:	Status
MAT implementation in SPAs 1 & 7			
1. DCFS and DMH MAT staff hired and trained in SPAs 1 and 7.	Laura Andrade Gary Puckett	2/1/09	Completed
2. MAT staff in SPAs 1 and 7 trained on MAT process.	Laura Andrade Gary Puckett	2/1/09	Completed
3. MAT providers in SPAs 1 selected and contracts signed	Gary Puckett Ana Suarez	2/15/09	Completed
4. MAT providers trained on billing procedures	Gary Puckett Norma Fritsche	2/10/09	SPA 7 – Completed SPA 1 - Pending
5. MAT cases referred to MAT providers when training is completed.	Roberta Medina Art Lieras Ana Suarez Laura Andrade Gary Puckett	2/16/09	Started
6. Full MAT implementation in SPAs 1 and 7.	Roberta Medina Art Lieras Ana Suarez Marty Nagel Paul Gaeta Laura Andrade Gary Puckett	7/31/09	Pending
MAT Implementation in SPAs 2, 4, 5, and 8			
1. DCFS MAT staff hired for SPAs 2, 4, 5 & 8.	Laura Andrade	2/28/09	Completed
2. DMH MAT staff hired.	Gary Puckett	3/1/09 – 6/30/09	Pending
3. DCFS MAT Staff trained for SPAs 2, 4, 5,& 8	Laura Andrade Gary Puckett	1/30/09	Completed
4. DMH MAT staff trained.	Gary Puckett	3/1/09 – 6/30/09	Pending
5. MAT providers selected by SPA District Chiefs for SPAs 2, 4, 5 & 8.	Gary Puckett SPA District Chiefs	2/6/09	Completed

6. MAT Providers have signed DMH contracts	SPA District Chiefs MAT Provider Agencies	3/1/09 – 6/30/09	Pending
7. DCFS Staff and MAT providers trained on the MAT program.	DCFS RAs District Chiefs MAT Providers DCFS Regional Staff Gary Puckett Laura Andrade	3/1/09 – 6/30/09	Pending
8. MAT providers trained on billing procedures	Gary Puckett, Norma Fritsche, Provider Agencies	3/1/09 – 6/30/09	Pending
9. DCFS MAT cases referred to MAT providers.	DCFS RAs DMH District Chiefs MAT Provider Agencies Laura Andrade Gary Puckett	3/1/09 – 6/30/09	Pending
10. Full MAT implementation in remaining SPAs 2, 4, 5 & 8.	DCFS RAs DMH District Chiefs Provider Agencies Laura Andrade Gary Puckett	1/31/10	Pending

Resources:

1. MAT CSA I, Administration, recently hired to provide central support for DCFS MAT manager, is currently being trained.
2. Fifteen (15) of seventeen (17) DCFS MAT coordinator positions have been hired. The remaining positions to be hired and trained by mid April.
3. MAT provider agencies already operating in SPAs have sufficient capacity to meet DCFS needs.
4. Current MAT providers will expand to serve other SPAs.
5. MAT providers are willing to add staff to meet DCFS demands.

Dependencies:

1. MAT contracts are signed by MAT provider agencies starting the MAT Program Implementation;
2. Finalization of Consent Policy;
3. Finalization of Benefits Establishment Policy; and

4. MAT provider capacity to meet DCFS demands.

Customer Benefits:

1. Children with mental health needs are assessed quickly;
2. Quick identification of client needs and linkage to appropriate resources;
3. Most appropriate placement for child and family needs; and
4. Children are linked to appropriate and viable mental health services.

Issues and Risks:

1. MAT requires county wide implementation to function most efficiently.
2. MAT requires identification of ongoing treatment funds to work efficiently.
3. HIPPA law creates challenges in sharing of information.
4. MAT automated system required to log and document MAT referrals and completions.
5. Not completing other work flow processes (MHST, Consent, and Benefits Establishment) prevents effective implementation.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #5- Referral Tracking System (RTS)	
Start Date: March 1, 2008	
Sponsors: Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director	
Project Managers: Cecilia Custodio, DCFS Lisa Sorensen, DCFS John Ortega DMH Gary Puckett, DMH	
Background: The development of an automated and streamlined process is crucial to ensure all children entering DCFS and currently in an open DCFS case receive needed Mental Health Services (MHS). Currently, no systematic process exists to ensure these children are routinely screened, assessed, and linked to MHS across the county. There are no consistent policies and procedures, and manual logs are utilized to track and produce data. As policies and procedures are developed that delineate referral, service linkage, and quality assurance processes, staff and managers require a technologically based system to track and monitor the workflow process and ensure compliance.	
Project Objective:	**Expected Operational Date:**
1. Phase I: Build interim RTS processes on the DCFS side to eventually automate, streamline and track referral process to DMH; and build capacity on DMH side to receive this data and produce matched client linkage data.	4/1/09
2. Phase 2: Build automated RTS on the DMH side that aligns with the Katie A. Data Inventory to track progress, and disposition of DCFS referrals, assessments, and DMH service linkage; and to include, if granted by the State, DMH access and data entry into CWS/CMS.	8/1/09
Expected Outcomes: 1. Increase ability and efficiency to track workflow process to ensure all children are screened, assessed and linked to MHS as needed; 2. Simplify collection and production of data to identify/overcome barriers and demonstrate compliance in collecting discrete data	

indicators (Data Inventory) that the County is responsible to track in relation to the Katie A. Exit Conditions from the lawsuit.			
Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
Phase I			
1. Production of sample data run prior to implementation	Cecilia Custodio Lisa Sorensen John Ortega	2/1/09	Completed
2. Write Statement of Work (SOW) for interim tracking of mental health referrals/receipt of services and for DMH co-located staff to have access to CWS/CMS and obtain approval from County Counsel and Information Services Division (ISD).	Lisa Sorensen	3/1/09	In progress
3. Write RTS User Guide.	Lisa Sorensen	3/1/09	In progress
4. Five (5) DCFS Information Technology staff hired.	Cecilia Custodio	2/1/09	4/5 selected
5. Submit SOW to County Counsel and the State to give DCFS authority to allow DMH staff access to CWS/CMS.	Lisa Sorensen	10/1/08 – 4/1/09	In progress
6. Identify Special Project Fields within CWS/CMS to manually track referrals to and receipt of mental health services	Cecelia Custodia	3/1/09	Completed
7. Develop and provide training to DCFS/DMH SPA 7 staff.	Mark Miller Angela Shields	3/1/09	In progress
8. Pilot RTS interim processes in SPA 7 offices and produce initial reports.	Roberta Medina Art Lieras Ana Suarez Adrienne Olson Greg Lecklitner	3/1/09 – 6/1/09	In progress
9. Develop utilization and compliance reports to help manage daily operations.	Lisa Sorensen Cecilia Custodio	4/1/09	In progress
Phase II			

1. Write SOW and obtain approval from County Counsel and ISD.	John Ortega	12/1/08 – 3/31/09	Draft SOW submitted to County Counsel
2. Hire Project Manager.	John Ortega	3/31/09 – 5/1/09	Pending
3. Define business rules & build RTS on DMH side.	TBD Project Manger	5/1/09 – 10/1/09	Pending
4. Develop Training.	Mark Miller Angela Shields	TBD	Pending
5. Provide Training.	Mark Miller Angela Shields	TBD	Pending
6. Pilot Phase II RTS in SPA 7.	TBD	TBD	Pending

Resources:

1. Five (5) DCFS IT staff approved for hire to help support, (in part), development and ongoing work of RTS.
2. Service Linkage Specialist (SLS) CSA II, seven (7) SLS CSA IIs, and seven (7) screening clerks approved for hire that will collect and enter data, oversee process and troubleshoot.
3. DMH Project Manger and other IT Staff approved for hire.

Dependencies:

1. Phase I: Timely completion of policies/procedures for completion of MH Screening, Consent, Benefits Establishment to meet deadlines for system to be built, and training to be developed and provided to staff.
2. Phase I: Ability on DCFS management side to absorb additional duties prior to new IT and management staff being hired.
3. Phase 2: SOW pending approval from County Counsel.
4. Phase 2: Project Manager on DMH side to be hired.
5. Phase 2: State approval for DMH staff to access and enter data into CWS/CMS.

Customer Benefits:

1. Consistent practice for client referral that produces results;
2. Streamlined and automated process to ease workload; and
3. Administrative support/oversight and data collection to ensure accountability and fulfillment of responsibilities by all team members.

Issues and Risks:

1. The Departments are unable to track and produce reports to demonstrate all open cases are screened, assessed and linked as needed to MHS without RTS.
2. SACWIS regulations prevent the creation of the most efficient system possible and create technological barriers.

3. HIPPA law creates challenges in sharing of information. 4. Resistance of staff to change with perception of additional work load. 5. Risk of not completing other work flow processes (MHST, Consent, Benefits Establishment) prevents completion of project.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #6- Consent/Release of Information	
Start Date: March 1, 2008	
Sponsors: Dr. Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
Project Managers: Greg Lecklitner, DMH Lisa Sorensen, DCFS	
Background: One of the issues that frequently causes delays in assessment and treatment of DCFS children is the lack of consent to authorize DMH and its providers to provide mental health services. Many providers have required court orders for assessment and/or treatment in lieu of parental consent; each agency has its own forms required to authorize parental consent. Seeking court orders for treatment bypasses contact with the child's parents, when, in most mental health settings, obtaining consent for treatment is a means by which parents are typically engaged in their child's treatment. It is time consuming and an additional workload for CSWs to request consent for treatment from the court. DCFS has also identified several points within its service delivery system where different consent and release of information forms are needed (such as Wraparound and Family Preservation).	
Project Objective:	**Expected Operational Date:**
1. Create one Consent form and one Release of Protected Health Information form that can be used by all DCFS programs, DMH directly operated services and contracted providers.	3/1/09
2. Change DCFS, Dependency Court, DMH and DMH providers practice standards to first seek consent and engagement with parents before turning to the courts for permission to treat DCFS dependents.	6/1/09
Expected Outcomes: 1. As children are screened for possible mental health needs, they will be assessed and linked to service without delay due to lack of consent for treatment and authorization for release of information. 2. Parents will be more readily involved in the child's therapy, which will lead to earlier reunification and a shorter duration for family maintenance cases. 3. DMH and provider agencies will be able to better predict how many slots they will need to serve children and slots will be filled	

more quickly with fewer delays around consent and authorization to release information.			
Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Develop Consent for Treatment and Authorization for Release of Protected Health Information forms to be used for all services provided directly by DCFS, DMH or their provider agencies.	Adrienne Olson Greg Lecklitner	3/1/09	In progress
2. Develop language to be used in Dependency Court to request the court's order for treatment and the release of protected medical information.	Adrienne Olson Guy Trimarchi	3/1/09	In progress
3. Develop DCFS and DMH policies regarding obtaining consent and release of protected mental health information.	Guy Trimarchi John Coyle Lisa Sorensen	3/1/09	In progress
4. Meet with mental health providers to discuss the universal consent form; to understand their needs and to seek their review and comments on the forms.	Greg Lecklitner Lisa Sorensen	2/1/09 – 5/1/09	In progress
5. Develop and provide training to DCFS and DMH staff and mental health providers on the use of the new forms.	Mark Miller Angela Shields	TBD	Pending
6. Present the new forms to the Dependency Court judges and receive feedback. Explain situations in which the court's consent will still be sought.	Lisa Sorensen	TBD	Pending
7. Continue to work with DCFS and DMH staff and the provider community to further refine the use of the universal consent and release of information forms.	Greg Lecklitner Lisa Sorensen	3/1/08 – 3/15/09	In progress
Resources: 1. Existing workgroup devoted to resolving issues of consent and release of information; 2. DCFS has one policy analyst devoted to issues of health and mental health; and 3. DMH has a contract staff devoted to writing policies.			
Dependencies: 1. Providers must be willing to accept forms that are not agency specific.			

2. Courts must be willing to allow for parental consent as the first option for obtaining consent and release of information.
3. CSWs will need training that will adequately educate them on the concepts of informed consent and release of information; and how to engage parents in the process by helping them to understand the benefits of mental health treatment.

Customer Benefits:

1. Consistent practice for obtaining consent and release of information across all mental health providers;
2. Children and families will be able to receive mental health treatments without delay due to lack of consent/release of information;
3. Parents will be more readily engaged in their child's therapeutic process; and
4. Workload for CSWs will be reduced as fewer requests for consent for mental health treatment and release of information will need to be submitted to the court.

Issues and Risks:

1. Without universal consent and release of information forms, children will face delays in service delivery;
2. CSWs will face increased workloads as they must prepare a report for the dependency court;
3. Resistance of staff to change with perception of additional workload; and
4. Mental health providers may not come to a consensus regarding the content of the consent and release of information forms.

PROJECT TEAM MEMBERS

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: # 7**-** Benefits Establishment	
Start Date: March 1, 2008	
Sponsors: Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director	
Project Managers: Lisa Sorensen, DCFS	
Background: The development of a process to screen for, determine and establish benefit eligibility for children and families served by DCFS has become crucial to the goal of delivering mental health services to children who need them in a timely manner. Although DCFS has always been able to establish immediate presumptive Medi-Cal eligibility for children who are detained from their parents, the Department has no current process in place to accurately determine and establish eligibility for children who are served while in their homes. At this time DCFS has been referring children and families to services that are later found to be unavailable to them due to lack of full scope Medi-Cal or other benefits. With the ability to accurately assess benefits that a child is currently receiving or is eligible for, and providing some assistance to parents and caregivers to get those benefits, more children served by DCFS will be linked to services that are available to them.	
Project Objective:	**Expected Operational Date:**
1. Phase I: Create a process for benefits determination for all new cases that can be followed using existing resources available at this time to DCFS for offices in SPAs 1, 6 & 7 and co-located DPSS Linkages staff. Refine and standardize current processes in place in these offices to address unanticipated lapses in Medi-Cal benefits for children on currently open cases.	4/1/09
2. Phase 2: Explore options with DPSS and other County partners that will allow staff located within DCFS Regional Offices to have adequate training to navigate the several different Medi-Cal programs, from enrollment to benefit re-determination, to ensure maximum opportunities for children served by DCFS to receive the services they need.	4/1/10
Expected Outcomes: 1. Increase ability and efficiency to track workflow process to ensure all children are screened, assessed and linked to Mental Health	

Services as needed and reduce the number of children for whom treatment is disrupted or unavailable due to lapses in Medi-Cal eligibility.
2. Eligibility for all benefits established for children and families served by DCFS and all families eligible for Medi-Cal (through CALWorks or General Relief) or Healthy Families assisted with enrollment by staff with additional training in Medi-Cal eligibility.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
Phase I			
1. Develop DCFS and DMH policies for benefit establishment as part of CSAT implementation in SPAs 1, 6 & 7	Guy Trimarchi Lisa Sorensen Roberta Medina John Coyle	2/1/09	In progress Draft policy created
2. Write Benefits Establishment User Guide, including directions for data entry for tracking purposes	Lisa Sorensen	3/1/09	In progress
3. Develop on-going training to DCFS Revenue Enhancement, Technical Assistants and SAAMS staff	Teresa Arevelo Roberta Medina Mark Miller	3/1/10	Will be concurrent with CSAT training
4. Provide ongoing training to DCFS Revenue Enhancement, Technical Assistants and SAAMS staff as CSAT is implemented in SPAs 1, 6 & 7	Teresa Arevelo Roberta Medina Mark Miller	4/1/10	Will be concurrent with CSAT training
5. Pilot the Benefits Establishment process in SPA 7	Roberta Medina Lisa Sorensen Roberta Spears-Mathews Laura Andrade	4/1/09	Pending
6. Analyze data from the data tracking system to establish baseline performance regarding benefits establishment, including numbers of children not eligible, not enrolled, unanticipated disenrollments and average time to resolve these issues.	Teresa Arevelo Roberta Medina Roberta Spears-Mathews Laura Andrade Lisa Sorensen	9/1/09	Data collection to begin when implementing CSAT

7. Analysis of the most common scenarios in which benefit establishment has not been possible, has been difficult to resolve or has lapsed. Identify areas that require additional Medi-Cal eligibility expertise and determine the volume of cases affected in different scenarios.	Roberta Spears-Mathews Laura Andrade Teresa Arrevelo	12/1/09	Pending
8. Develop recommendations to increase the efficiency of benefit eligibility Department-wide including recommendations for staffing, training and technology needed.	Lisa Sorensen	12/31/09	Pending
Phase II			
1. Conduct meetings with DPSS managers to define resources and areas of training needed to increase DCFS' ability to access, understand and support benefits determination and eligibility for children in relative and parent care.	Adrienne Olson Lisa Sorensen	12/1/09	In progress
2. Develop a proposal for Benefits Establishment to occur within or with greater assistance from DCFS.	Adrienne Olson Lisa Sorensen	1/1/10	Pending
3. Consult with County Counsel regarding the proposal and revise as needed.	Adrienne Olson	2/1/10	Pending
4. Seek Board of Supervisors' (BOS) approval for proposal.	Dr. Sophy	3/1/10	Pending
5. Develop an implementation plan	Adrienne Olson Lisa Sorensen	5/1/10	Pending
Resources: 1. Current Revenue Enhancement Eligibility staff, Technical Assistants and SAAMS clerks in each office. 2. Co-located DPSS Linkages staff to be housed in all DCFS offices.			
Dependencies: 1. Phase I: Timely implementation of CSAT in SPA 7. 2. Phase I: Ability on DCFS management side to absorb additional duties. 3. Phase 2: Approval by BOS to implement a new plan that may have costs to the County and State associated.			

4. Phase 2: State approval for staff in DCFS offices to have greater access to the MEDS system.

Customer Benefits:

1. CSWs will not be required to navigate problems with Medi-Cal benefits.
2. More children will receive the services they need as benefits are established and maintained.
3. Decreased service delays will reduce the workload for CSWs and co-located DMH staff.

Issues and Risks:

1. Despite having a better Benefits Establishment process, the State budget crisis may have a negative impact on children's eligibility for benefits.
2. The State closely controls the number of users allowed to access the MEDS system.
3. Perception of additional workload may result in resistance of staff to change.
4. Many unknown issues around benefits establishment for children served by DCFS make project planning dates unreliable; plans are subject to considerable variability until more is known.

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Teresa Arevelo, DCFS		

County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #8- D-Rate	
Start Date: March 1, 2009	
Sponsors: Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
Project Managers: Tina Mosley, DCFS Kelly Butler, DMH Mariam Cardona, DMH	
Background: The D-Rate Program (D-Rate) assists to CSWs by identifying and assessing the mental health and behavioral needs of children, and ensuring that caregivers' homes meet the children's identified needs in accordance with the provisions of the Katie A. Settlement Agreement. D-Rate is a special funding category for relative and foster care providers who have received additional specialized training to provide care for children with special needs due to a mental health diagnosis.	
Project Objective:	**Expected Operational Date:**
1. Monitor children receiving the Specialized D-Rate payment to ensure that the rate and mental health services are appropriate.	Ongoing
2. Integrate D-Rate into the Coordinated Services Action Team (CSAT) process, providing intense focus on adequately addressing the mental health needs of high needs DCFS supervised children.	Ongoing
Expected Outcomes: 1. Each child's case is reviewed/re-certified annually to evaluate progress, review and revamp goals, and to modify treatment options. 2. Increase support to regional CSWs by locating resources and linking children to services on their caseloads. 3. D-Rate evaluators have more visible roles through participation on teams on behalf of the children and caregivers. 4. Improved follow-up and linkages for DCFS children receiving psychotropic medication. 5. Improved planning and outcomes for children discharged from psychiatric hospital stays.	

Deliverables:	Project Lead(s):	Planned Timeline:	Status
1. Timely completion of D-Rate assessments	Kelly Butler Miriam Cardona	Ongoing	In progress
2. Timely completion of D-Rate re-assessments	Tina Mosley	Ongoing	In progress
3. Assist the CSW with the formulation of a case plan that will meet the child's specialized and specific needs, including three (3) to five (5) goals to be attained annually. These goals will include the provision of resources, community support and linkages, and brokerages to comprehensive and innovative mental health services.	Tina Mosley	Ongoing	In progress
4. D-Rate evaluators contact all caregivers whose children are prescribed psychotropic medications to inquire about side effects and linkages to psychiatric services.	Tina Mosley	Ongoing	In progress
5. Work with D-rate foster caregivers to help achieve improved outcomes for their children and address their needs and concerns, including direct access to a knowledgeable Clinical D-rate Evaluator to address their concerns.	Tina Mosley	Ongoing	In progress
6. D-Rate evaluators in the regional offices conduct hospital discharge teleconferences for DCFS children.	Tina Mosley	2/24/09	Ongoing
7. D-Rate evaluators assist regional staff to locate placements for children with mental health needs.	Tina Mosley	Ongoing	In progress
8. D-Rate evaluators identify caregivers to potentially become D-Rate certified.	Tina Mosley	Ongoing	In progress
9. D-Rate evaluators will have more visible role through participation on teams on behalf of the children and caregivers.	Tina Mosley	Ongoing	In progress

10. D-Rate evaluators to assist in resolving issues related to children discharged from psychiatric hospitalization without sufficient psychotropic refill amount.	Tina Mosley	Ongoing	In progress
11. D-Rate evaluators to complete 40 day follow up court report and monthly phone contact with caregiver/child regarding Psychotropic Medication Follow-Up questionnaire.	Tina Mosley	Ongoing	In progress

Resources:

1. One (1) CSA II – D-Rate to act as central administrator for the D-rate program;
2. One (1) STC supports CSA II;
3. One (1) CSA 1 to oversee hospital discharge teleconferences, Rate Classification Level 14 Screening Process;
4. Two (2) SCSW's oversee 8 D-Rate evaluators each;
5. Sixteen (16) D-rate CSW IIIs – conduct D-Rate re-evaluations and perform duties related to the Psychotropic Medication Authorization Process;
6. Two (2) STC's support SCSWs and D-Rate evaluators
7. Two (2) STCs reclassified from existing ITCs to carryout additional duties related to Psychotropic Medication Authorization Process;
8. One (1) STC to carryout additional duties related to Psychotropic Medication Authorization Process; and
9. DMH staff to provide the initial assessment to determine the child's D-rate eligibility.

Dependencies:

1. CSWs must refer children to the D-Rate unit for initial assessments with DMH;
2. Caregivers must be available for D-Rate evaluators to complete the annual re-assessment;
3. CSW and caregivers to work collaboratively with D-Rate staff to obtain updated information on psychotropic medication;
4. Hospitals must report DCFS admissions for teleconferencing and discharge planning;
5. Region to contact D-Rate unit for assistance on high end cases on an ongoing basis;
6. DMH to complete timely initial assessments;
7. Systems Linkage Specialists to include D-Rate staff in CSAT process; and
8. Edelman's Children's Court to notify D-Rate Psychotropic Medication Authorization clerks of the 40-day progress report date in a timely manner.

Customer Benefits:

1. Children with severe mental health needs will be assessed and re-assessed on an ongoing basis to ensure receipt of timely and adequate mental health linkages and services;

2. CSWs will receive improved case planning support for children with mental health needs; and
3. Each child receiving psychotropic medication will receive follow up from D-Rate evaluators to ensure each child is provided linkages when needed.
4. Adhere to requirement to reduce foster care payment rate as children's mental health functioning improves.

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PROJECT DATA SHEET	
Project Name: #9- Resources Management Process (RMP)	
Start Date: December 1, 2008	
Sponsors: Lisa Parrish, DCFS, Deputy Director Olivia Celis-Karim, DMH, Deputy Director	
Project Managers: Michael Rauso, DCFS Angela Shields, DMH Marilynne Garrison, DCFS	
Background: The development of a standardized multi-disciplinary team process to review children/youth at risk of, currently in, or leaving residential care is crucial to ensure the appropriate level of mental health services, either community based services or short term residential care. The Resources Management Process (RMP) provides a standardized multi-disciplinary process that allows children/youth, their family and family supports an opportunity to participate in decision-making when a youth is at risk of entering, moving, or leaving residential care. RMP incorporates an objective placement tool, the Child and Adolescent Needs and Strengths (CANS), to support the team's decision making. Dr. John Lyons conducted a system delivery review of Los Angeles County and developed a "decision score" that is used with the CANS to assist the members in the RMP objectively identify the level or care needed. In 2008, select DCFS, DMH and community staff were trained on the CANS. Another important aspect of the RMP is the ability to bring community resources to the CSW. Due to the increase of available community based services, there has been a lack of consistent, timely and appropriate referrals to the newly created programs. The RMP creates a streamlined process, which brings the services to the RMP to expedite linkage with the appropriate mental health services.	
Project Objective:	**Expected Operational Date:**
1. Develop a RMP policy with DMH and referral form (DCFS 174) that is used countywide	12/1/08
2. Mandate and standardize the RMP for all replacements of children/youth at risk of entering, currently in, or leaving an RCL 6-14.	12/1/08
Expected Outcomes: 1. Increase ability and efficiency to link DCFS children/youth to the appropriate mental health services; 2. Decrease the number of replacements for DCFS children/youth;	

3. Decrease the number of days spent in out of home care; and
4. Increase the number of community based mental health referrals.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
Phase I			
1. Develop a RMP policy and DCFS 174	Michael Rauso Angela Shields Marilynne Garrison Guy Trimarchi John Coyle	12/1/08	Completed. Updates made to policy.
2. Train DMH co-located staff and DCFS Resources Utilization Management (RUM) staff to administer the CANS.	Rosa Nafariyeh Angela Shields David Cantu	6/1/08	On-going
3. Develop a system to track the number and outcome of RMP meetings.	Michael Rauso Marilynne Garrison Angela Shields Nina Powell-McCall Omar Santos	12/1/08	In progress
4. Community outreach to all the DCFS offices to reinforce the RMP policy and trouble shoot.	Michael Rauso Marilynne Garrison Angela Shields	1/1/09	In progress
5. Evaluate data from RMP.	Michael Rauso Angela Shields Marilynne Garrison Omar Santos	12/1/08	In progress

Resources:

1. Seventeen (17) DCFS RUM and seventeen (17) DMH clinicians were approved and hired to implement and complete the CANS, and support RMP objectives

Customer Benefits:

1. Consistent practice for line staff; children/youth, their family and supports; DMH clinicians and our community partners in the placement and/or linkage to mental health services;

2. RMP will focus on permanency for children in or at-risk of placement in an out-of-home care by establishing a Departmental commitment to ensure the safe return of children to family or to a permanent home without an extended stay in residential care;
3. Streamlined process to ease referrals, workload and linkage;
4. Multi-disciplinary team approach for better decision-making; and
5. RMP data will allow DCFS to evaluate the service delivery practice of children accessing foster care services and implement timely modifications for system reform.

Issues and Risks:

1. Without RMP:
   - Entry into residential care and referrals to community based services will be inconsistent and may not be appropriate;
   - CSW and youth/family will not benefit from a multi-disciplinary team to assist in the decision-making and understanding of the best available resources;
   - CSW must fill out redundant referral forms and be expected to understand the referral criteria of all existing and new programs;
   - Children/youth, their family and supports will not have an opportunity to contribute to the team decision-making process; and
   - Providers and other caring professionals will not be able to contribute to the team decision-making process.
2. Resistance of staff to change with perception of additional work load and perceived “loss of decision-making control.”

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET

Project Name: #10- DMH Specialized Foster Care Co-Located Programs

Start Date: January 1, 2005

Sponsor:
Olivia Celis-Karim, DMH Deputy Director

Project Managers:
Janel Jones, DMH
Jacqueline Wilcoxen, DMH
Brad Bryant, DMH

Background: The co-location of DMH staff in the DCFS regional offices (Specialized Foster Care) has been a critical component of the 2005 Enhanced Specialized Foster Care Plan, 2007 Corrective Action Plan, and the 2008 Katie A. Strategic Plan, to improve timely access to screening, assessment and appropriate mental health treatment for children involved in the DCFS child welfare system. The DMH clinical staff provides an array of mental health services including: follow-up on the CIMH screening tool; assessment; brief treatment; crisis intervention, and linkage to mental health service providers in the community. DMH staff will also attend and participate in the Team Decision-Making (TDM) meetings, and have an integral role in the RMP case planning and decision-making process.

Project Objective:	**Expected Operational Date:**
1. Develop co-located DMH Specialized Foster Care Units in the eight DCFS offices in SPAs 1, 6 and 7. (Phase I)	1/1/ 05 – 1/1/07
2. With existing and additional staffing, reconfigure DMH ICAT programs, and develop co-located DMH Specialized Foster Care Units in the DCFS offices in SPAs 2, 3, 4, 5, and 8. (Phase II)	SPAs 2, 4 & 8 – 11/1/08 SPAs 3 & 5 – 3/1/09

Expected Outcomes:
1. DMH Specialized Foster Care staff, in collaboration with CSWs, CSAT members, and community providers, will improve access to appropriate mental health treatment for children and families.
2. More appropriate and comprehensive case planning will occur because of having mental health staffs participate as members of the TDM process.
3. Children will have increased permanency and stability by having access to the most appropriate mental health services as soon as possible.

Deliverables:	Project Lead(s):	Planned Timeline:	Status
1. All DMH Specialized Foster Care units will be fully staffed and operational.	Janel Jones Angela Shields Greg Lecklitner Bryan Mershon	August 1, 2009	Current positions filled. Twenty (20) additional positions allocated 7/1/09.
2. DMH Specialized Foster Care units decentralized and integrated under the local Service Area District Chief.	Janel Jones Angela Shields Greg Lecklitner Bryan Mershon	8/1/09	SPAs 3, 4, & 5 - in progress. SPA 2 & 8 - 8/1/09
3. All SFC Programs will follow consistent policies and procedures as provided in the Child Welfare Division Policies and Procedures Manual	Greg Lecklitner Janel Jones	2/1/09	Three (3) policies in progress. Consultant on board to assist.
4. DMH SFC staff will receive training, support and supervision to develop the knowledge and skills to be successful	Angela Shields Mark Miller	SPA 7: DMH/DCFS training – 3/1/09	Specific mental health training ongoing. See Training.

Resources:

1. Administrative support from the DMH Service Areas District Chiefs and DCFS management in regional offices;
2. DMH Child Welfare Division and DCFS Training Sections; and
3. Program Managers are responsible for developing, and implementing program guidelines and policies, as well as clinical operations.

Dependencies:

1. Approval of Clinical Program Manager positions to develop and maintain the new programs and coordinate with other important components of the Katie A Strategic Plan such as MAT, WRAP and intensive in home services.
2. Retention of qualified and experienced clinical staff that can function in a fast paced, stressful interagency work setting.
3. Local managers from DCFS and DMH informed and committed to working together to successfully implement the Katie A. Plan.
4. Allocation of necessary space in the DCFS offices and assistance with the requirements of Medi-Cal certification in all offices, i.e. fire clearances, maintenance agreements, interview space, etc.

Customer Benefits:

1. Children involved in the DCFS system for reason of child abuse and/or neglect will have increased mental health stability and well being, due to receiving early screening, assessment and referral to appropriate mental health services.

2. Children will have increased permanency and fewer placements, as well as a reduced risk of removal from their homes in the first place due to receiving earlier assessment and treatment for their mental health problems.

Issues and Risks:

1. High expectations and work load on a small number of mental health staff assigned to each large office.
2. Increased severity and complexity of mental health issues presented by children and families referred to DCFS.
3. Capacity of the mental health community providers to respond to the increased demand for services.
4. Staff turnover of experienced clinicians within the mental health units.
5. High mental health needs of children/youth already placed in long term foster care and will be aging out of the system with limited resources available to meet their needs.
6. Increased workload on limited clerical support staff to meet the tracking and data entry needs of the units.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET

Project Name: #11- Wraparound Expansion

Start Date: May 1, 2009

Sponsors:
Lisa Parrish, DCFS, Deputy Director
Olivia Celis-Karim, DMH, Deputy Director

Project Managers:
Michael Rauso, DCFS
Angela Shields, DMH

Background:
Wraparound started as a pilot project in Santa Clara County, California in response to the Title IV-E Waiver of the Social Security Act that permitted flexibility in the use of Aid to Families with Dependent Children, Foster Care (AFDC-FC) funds for eligible children. Senate Bill 163 (October 8, 1997) extended Wraparound to all counties in California. In Los Angeles County, Wraparound started in 1998 as a 10-child public agency pilot at MacLaren Children's Community Shelter (MCC) and in 2001 shifted to a lead provider agency model. In May 2003, there were 175 youth enrolled in Wraparound and eight contracted providers. Because of the positive outcomes Wraparound demonstrated, the County moved to expand Wraparound in 2006 to contract with 35 providers, increasing the potential number of youth served. In 2007, as part of the Katie A. Settlement Agreement, Judge Matz ordered Los Angeles County to expand the Wraparound census by 500 by June 2008 (to 1,217 slots) which was surpassed in May 2008 reaching 1,245 filled slots. In FY 08/09, Wraparound was expanded to 1,400 slots, referred to as Tier 1.

In May 2009, as indicated in the Katie A. Plan, Wraparound will expand again to serve 2,800 additional DCFS youth that have an identified intensive mental health need, have Early Periodic Screening Diagnosis and Testing (EPSDT) eligibility and do not meet the current Wraparound criteria of Rate Classification Level (RCL) 10 and higher. This expansion will create a tiered system to differentiate the current Wraparound population placements from the newly created criteria. Originally, the Strategic Plan proposed a three-tiered system with differing case rates and EPSDT reimbursement rates. However, after identifying implementation and practice issues, it was decided to create a two-tiered plan:

- Tier 1 - traditional Wraparound referral criteria; and
- Tier 2 – comprised of 749 additional Full Service Partnerships (FSPs) and 2,051 DCFS generated slots for those children with

intensive mental health needs who do not meet the RCL 10 or above Wraparound referral criteria. This new service provision will assist the providers, the County and the case workers in expediting services to families.

Project Objective:	**Expected Operational Date:**
1. Increase the number of DCFS youth receiving Wraparound	5/1/09

Expected Outcomes:

1. Increased ability and efficiency of families to care for their children;
2. Decreased number of placements and/or replacements for DCFS children/youth;
3. Decreased number of days spent in DCFS and out of home care;
4. Increased number of community based mental health linkages, both formal and informal;
5. Increased number of families that reunify and achieve permanency (reduce recidivism); and
6. Increased well being of families receiving Wraparound, including improved educational functioning.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Develop an updated Wraparound policy	Michael Rauso Angela Shields Guy Trimarchi John Coyle	2/17/09	In progress
2. Develop a tracking system to account for the number of Wraparound youth enrolled and outcomes	Michael Rauso Angela Shields Pam Dubin Omar Santos	5/1/09	In progress
3. Develop an MOU between DCFS, Probation, and DMH for the provision of Wraparound services inclusive of case rates and EPSDT reimbursement	Michael Rauso Angela Shields Patrick Lemaire	3/1/09	In progress
4. Execute the extension for the current Wraparound providers with the inclusion of the new referral criteria and other program elements.	Michael Rauso Angela Shields	5/1/09	Draft Statement of Work submitted to County Counsel
5. Data and outcomes tracking and reporting	Michael Rauso Angela Shields Pam Dubin Shirley Robertson	5/1/09	In progress

6. Training – public agency staff – Wraparound Expansion	Mark Miller Inter-University Consortium (IUC) Sherman Mikle Angela Shields David Cantu	4/1/09	Curriculum development in progress
7. Training – coaching and mentoring – provider staff	Sherman Mikle Angela Shields Shirley Robertson Mark Miller IUC	5/1/09	Curriculum review and trainer selection in progress

Resources:

1. Seventeen (17) DCFS Wraparound staff approved for hire to implement the new Wraparound expansion.
2. Eight (8) DMH Wraparound staff approved for hire to implement the new Wraparound expansion.

Customer Benefits:

1. An effective process that has been demonstrated to decrease placements/replacements for DCFS children/youth and increase the number of families that reunify, achieve permanency and decreased recidivism;
2. Supports the family's voice and choice in plan development;
3. Models a teaming process that promotes open communication around strengths, needs and accessing informal community supports that the family can continue after they graduate from Wraparound;
4. Develops one comprehensive, individualized plan that coordinates all supports and resources;
5. Wraparound will be available to more DCFS youth and their families.

Issues and Risks:

1. Appropriate and ongoing referrals to Wraparound.
2. Continued collaboration with partners to address individual departmental objectives surrounding referral criteria and outcomes.
3. Required ongoing and active participation/support by the CSW in the team process, which impacts:
   - The ability of the team to meet the court's mandates in a way that aligns with the family's vision of help and is based on the family's strengths;
   - The ability of the team to expand membership and reach consensus on an intervention and without concern for contradicting a CSW's case plan;
   - The ability of the team to persevere in a crisis and continue the planning process with the family;

- The ability of the family to understand the CSW's position and collectively develop a shared understanding of safety, permanency and well-being and the ways to get there together.

4. Resistance of staff to decisions made in a team and the ability to allow the team to creatively meet needs.
5. Managing the increased Net County Costs (NCC) for the Wrap expansion of the new DCFS Tier 2 slots.

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PROJECT DATA SHEET

Project Name: #12- Treatment Foster Care

Start Date: December 1, 2007

Sponsors:
Lisa Parrish, DCFS Deputy Directory
Olivia Celis-Karim, DMH Deputy Director

Project Managers:
Marilynne Garrison, DCFS
Gail Blesi, DMH

Background:
As part of the Katie A Settlement, the federal court ordered DCFS to provide 300 intensive Treatment Foster Care (TFC) beds for children with behavioral and emotional problems. Many seriously emotionally disturbed and behaviorally challenged foster children spend too many years in the highest level group homes (RCL 12, 14 and Community Treatment Facilities). The purpose of the Intensive Treatment Foster Care (ITFC) and Multidimensional Treatment Foster Care (MTFC) Programs is to provide therapeutic foster homes for individual children (ages 10-17) who have been in a high level group homes (RCL 12, 14 and Community Treatment Facilities), or are at serious risk of this level of treatment or at risk of psychiatric hospitalization. These children have improved outcomes in less restrictive home environments. While in TFC, a single youth is the sole foster child in the home. Foster parents are specially trained and selected based on their compatibility with each youth's needs. The foster parents are supported 24/7 by the contracted foster care agencies.

The ITFC program is Countywide and placement duration of ITFC is indefinite. Children placed in ITFC homes will have access to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice, when deemed clinically appropriate.

Currently limited to Service Provider Area (SPA) 6, the MTFC program will expand to SPAs 1 and 7 in the near future. MTFC is an evidence-based practice that has received the highest scientific rating by the California Evidence-Based Clearing house of Child Welfare. MTFC placements are short-term (6 to 12 months) and result in changing behaviors and preparing youth for placement with their family or permanent caregiver. Because it is currently available in SPA 6 only, MTFC is exclusively for youth whose permanent caregiver is located in or near SPA 6.

Efforts to comply with the court order to develop 300 foster care beds are now underway, however progress towards the realization of this Project Objective though slow, will be steady for the programmatic reasons noted below.

Project Objective:	**Expected Operational Date:**
1. Develop and fill 220 ITFC Beds	12/1/07
2. Develop and fill 80 MTFC Beds	12/1/07

Expected Outcomes:

1. Increased appropriate alternative to group home placement;
2. Increased access to behavioral intervention strategies;
3. Reduced behavioral problems;
4. Increased school success;
5. Increased placement stability;
6. Increased emotional stability;
7. Increased reunification with parents, family members or non-related extended family members;
8. Better relationships with family;
9. Increased life skills (social, vocational);
10. Reduced criminal behavior and drug use (MTFC);
11. Increased peer relationship skills (MTFC);
12. Increased happiness and life satisfaction; and
13. Reduced runaways (AWOLs).

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. MTFC training for staff of 3 foster family agencies (FFAs)	Todd Sosna, CIMH Tannel House, CIMH Gail Blesi, DMH CDT;	1/28/08 – 1/30/09	Completed
2. TF-CBT of ITFC agencies staff	Todd Sosna, CIMH; Margaret Faye, DMH;	2/12/08, 2/5/09	Initial training completed, on-going as needed
3. Institute Interagency Placement Review Team (IPRT) meetings	Virginia Baker Gail Blesi Margaret Faye RUM SCSWs	3/18/08	Completed, on-going weekly teleconferences

	FFA Program Supervisors		
4. Develop and publish "For Your Information" (FYI) for programs	Virginia Baker Amara Suarez Gail Blesi	11/08	Completed
5. Develop and print brochures for ITFC program	Virginia Baker Bob Rogers	8/08	Completed
6. Develop and print brochures, handouts and PowerPoint presentations for targeted marketing of MTFC program	Gail Blesi	1/2008	Completed
7. Presentations to Regional DCFS and DMH staff who are potential referral resources (e.g., Team Decision-Making facilitators, co-located DMH units, Permanency Planning Conference (PPC) workers, etc) and Children's Law Center to inform community partners	Bob Rogers Gail Blesi Virginia Baker	4/1/08, 11/5/08, 12/3/08, 12/10/08; 1/8/09, 1/13/09, & 2/3/09	2/10/09 , 2/11/09, 2/1209, 2/19/09, 3/10/09, 3/11/09, & 3/12/09: completed 4/7/09: scheduled; and on-going
8. Contact PPC facilitators for referrals for children meeting ITFC/MTFC criteria	Gail Blesi Virginia Baker	2/3/09 presentation	Presentation to PPC facilitators: completed, follow-up is on-going
9. Bi-Monthly DCFS/DMH Strategic Planning Update and Review meetings	Virginia Baker Gail Blesi Margaret Faye	5/12/08	In progress and on-going
10. Quarterly Providers Roundtables	Bob Rogers Virginia Baker	8/14/08	In progress and on-going quarterly
11. CMS Request to add Penny Lane to MTFC providers	Bob Rogers Margaret Faye	11/1/08	Pending
12. CMS Request to extend contracts for current agencies and add any with DMH contracts	Bob Rogers DCFS Contract Staff	1/2/09	In progress, requesting state approval
13. Request Regional Administrator's support for referrals to MTFC program via targeted in-person presentations	Bob Rogers Virginia Baker	3/31/09	Pending

	Gail Blesi Margaret Faye		
14. Develop on-line training regarding access to ITFC/MTFC for CSWs	Virginia Baker DCSF training staff	6/30/09	Pending

Resources:

1. DCFS staff consisting of one Program Manager and one Program Coordinator
2. DMH staff consisting of one Community Development Team (composed of California Institute of Mental Health [CIMH] staff and DMH staff) and Central Authorizing Unit staff.
3. FFAs providing MTFC staff one foster parent recruiter, one family therapist, one individual therapist, one skills trainer, and one Program Supervisor for every 10 youth placed. (The MTFC Program Supervisor leads the work of the foster parents and the MTFC treatment team, and is the point person for DCFS, attorneys, educators and all other community partners. For MTFC, FFAs are responsible for replacement training [including travel] costs and expenses associated with MTFC certification.) Five foster family agencies (three for ITFC and two for MTFC) are currently contracted to:
    - recruit and train foster parents in order to supply needed placements, and
    - staff Program Supervisors who support foster parents and mentor children while coordinating other supportive services.
4. Resource Utilization Management (RUM) staff provide consultation within each regional office, compile sufficient case information, present referrals to the IPRT and forward RUM packets to the providers for their review in consideration of a youth's placement.
5. DMH staff to provide consultation and participate in IPRT teleconferences.

Dependencies:

1. Education of DCFS and DMH staff for sufficient number of appropriate referrals to these programs;
2. Additional DCFS and DMH staff accommodate the administrative needs associated with each program;
3. Identified TFC liaison with Community Care Licensing (CCL) could ameliorate challenges associated with lengthy timeframe for certification;
4. Fast-tracking the contract process would address a major delay in the provision of TFC homes for the community; and
5. Additional DCFS clerical assistance for efficiency.

Customer Benefits:

1. Children participating in Treatment Foster Care receive more normalizing living environments and better opportunities for permanence, with fewer placement disruptions, AWOLS, less criminal behavior and drug use.
2. Children participating in Treatment Foster Care demonstrate better school adjustment, employment skills, improved peer

relationship skills, increased happiness and life satisfaction, and increased possibility of reunification with parents or relatives, and better likelihood of adoption.

Issues and Risks:

1. Without Treatment Foster Care:
   - Children will remain in group care long after benefit has been derived; and
   - DCFS will continue to pay for services that are no longer needed or effective for this population.
2. Development of needed foster home placements is challenging due to:
   - The demands that population's behavior places on the foster parents;
   - Foster parents need to complete and additional 40 hours of training specifically developed for ITFC and MTFC, in addition
   - to the training required to become a certified foster parent under the FFA,
   - Children need to have their own bedroom.
3. Delays in CCL clearances for foster parents has been a significant challenge during the initial phase of program development
4. Careful matching of the child with the foster parents takes time and requires sufficient referrals as well as available homes to choose from.
5. Low number of appropriate referrals from regional staff especially for the MTFC program as the program is relatively new and currently only available to youth whose permanent caregiver is located in SPA 6.
6. Program demands limited participation by FFAs resulting in only three identified agencies for ITFC and three for MTFC.
7. MTFC requires that the referred youth have a permanent placement to return to after treatment.
8. For MTFC, the permanent placement must reside in or around SPA 6.
9. Specialized referrals take extra attention and effort. Until staff becomes familiar with the benefits of this program, administration may need to encourage a minimum number of referrals from each regional office so that the availability of this valuable resource is highlighted and reinforced.

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PROJECT DATA SHEET

Project Name: #13- Finance

Start Date: March 2008

Sponsors:
Susan Kerr, DCFS, Senior Deputy Director
Olivia Celis-Karim, DMH, Deputy Director

Project Managers:
Cynthia McCoy-Miller, DCFS
Kimberly Nall, DMH

Background:
Ongoing funding to support the goals of the Katie A. Strategic Plan is crucial to the success of the County's efforts to meet the mental health needs of children in the foster care system. The County is currently providing about $40 million in County General Funds to support the County's response to the Katie A Settlement Agreement and that amount will increase to over $90 million once the Plan is fully implemented, absent the ability to identify additional federal and State funding through the efforts identified in the legislative project data sheet.

Project Objective:	**Expected Operational Date:**
1. To carefully monitor the program expenditures/revenues for the delivery of Katie A. services and to identify any savings from FY 08-09 associated with the incremental rollout of the Katie A. Strategic Plan and direct it to a Provisional Financial Uses (PFU) to offset costs in FY 09-10.	8/1/09
2. To coordinate legislative efforts with proposed budget development to mitigate the County's fiscal liability in FY 10-11 and beyond as program costs exponentially increase as full-year costs are realized when the plan is fully implemented in FY 14-15.	Ongoing

Expected Outcomes:
1. To monitor the Katie A. budget closely and in coordination with the legislative advocacy group, and the Plaintiffs' attorneys and Special Master in the State Katie A. case to develop proposals for submission to the State and/or Federal governments to mitigate the County's fiscal liability for implementing the Katie A. court-mandated services.
2. To ensure the delivery of Katie A. services are provided in the most fiscally prudent manner possible.

Deliverables:	Project Lead(s):	Planned Timeline:	Status
1. Revision of Wraparound/CFT tiered case rate and EPSDT revenue modified to two-tiered Wrap/CFT model: • Tier 1, case rate $4,184/EPSDT $2,246 – total slots 1,217 • Tier 2, case rate $1,250/EPSDT $2,246 – total slots 2,800, of which 2,051 are DCFS generated and 749 are DMH generated Full Service Partnerships (FSPs) – 523 child/226 Transition Age Youth (TAY) slots	Michael Rauso Angela Shields	2/1/09	Completed
2. Incorporation of Katie A. FY 09-10 costs as outlined in the 10/14/08 Adopted Strategic Plan and Budget.	Brian Mahan David Seidenfeld	3/1/09	Completed
3. Identification of FY 08-09 savings, including Title IV-E Waiver funds that can be redirected to provide services to class members.	Brian Mahan Susan Kerr David Seidenfeld	8/1/09	In progress
4. Identification of priority assignments not yet budgeted in the FY 09-10 Katie A. Strategic Plan Budget.	Adrienne Olson Greg Lecklitner	3/1/09	Completed
5. Appropriation adjustment and associated Board request for a Provisional Financial Uses (PFU) for Katie A. FY 08-09 savings.	Brian Mahan David Seidenfeld	9/1/09	In progress
6. Review of Federal Stimulus Package's Federal Medical Assistance Percentage (FMAP) two-year revenue enhancements to offset service costs to the Katie A. class in conjunction with the probable redirection of Mental Health Services Act (MHSA) monies and its impact on the budget.	Brian Mahan Susan Kerr David Seidenfeld CEO, Inter-Governmental Relations (IGR)	7/1/09 - 8/1/09	In progress
7. Incorporation of any fiscal relief resulting from legislative advocacy workgroup in the development of the FY 10-11 proposed budget	Brian Mahan David Seidenfeld	3/1/10	In progress

Resources:

1. FMAP increase to 61.6 percent for the next 27 months will result in the County receiving $1.60 per non-Federal matching dollar instead of the dollar per dollar match under the existing 50% FMAP. This additional revenue will help offset some of the County General Funds to pay for services to Katie A. class members.
2. Any regulatory, legislative, administrative proposals providing State/Federal relief to reduce the County's net county cost (NCC) for providing mental health services to Katie A. class and potential class members.
3. Title IV-E child welfare reinvestment funds.
4. Any fiscal relief provided by the Special Master in the State Katie A. case.

Dependencies:

Mitigation of County NCC for Katie A. related services is dependent on the "Resources" discussed above.

Customer Benefits:

To reduce the proportion of County General Funds used to fund the Katie A. Five-Year Strategic Plan, which when fully implemented in FY 14-15, is anticipated to have a total cost of $119.9 million.

Issues and Risks:

National/State/County budget crises will make it difficult to augment funding for Katie A. service delivery; however, with the Obama administration more progressive policies could be forthcoming from the Centers for Medicare and Medicaid Services (CMS**)**. The County will continue to work collaboratively with the Katie A. Advisory Panel, Plaintiff's attorney, and newly assigned Special Master in the State case to advance the interests of the County in exploring ways to maximize State/federal funding to support the delivery of intensive, home-based mental health services to Katie A. class members.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET

Project Name: #14- Caseload Reduction

Start Date: May 2008 **Updated:** March 2, 2009

Sponsors:
Ted Myers, DCFS, Chief Deputy Director,
Dick SantaCruz, DCFS

Project Managers:
Ted Myers, DCFS
Dick SantaCruz, DCFS

Background:
The ability to provide quality services to clients is directly impacted by the size of the caseload and workload of social work staff. DCFS has committed to lowering caseloads on several fronts. Focus will be placed on the Child Protection Hot Line (CPHL) to safety reduce the volume of calls "screened-in" for investigation and reducing of the number of referrals that require a response within 24 hours (i.e. Immediate Response). Additionally, the Department will move towards providing up-front assessments for after-hour clients that are served by the Emergency Response Command Post (ERCP) staff. Additionally, efforts will be made to reduce the total number of cases by expediting timelines to permanency and adoptions.

Project Objective:	**Expected Operational Date:**
1. Reduce front-end referral rates and case openings.	6/1/09
2. Increase permanency practice.	6/1/09
3. Increase or improve human resource practice and rates.	6/1/09

Expected Outcomes:
1. Reduction of Emergency Response (ER) caseload average to twenty-two (22) by 6/1/09, eighteen (18) by 6/1/10, fourteen (14) by 6/1/11.
2. Reduction of Generic caseload average to twenty-four (24) by 6/1/09, twenty (20) by 6/1/10, fifteen (15) by 6/1/11.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Hotline – reduce Screen-In rate from 88% to 70 %.	Cleo Robinson	6/1/09	As of 2/1/09, Screen-in rate has

Reduce Immediate Response (IR) referrals from 52% to 30%.			dropped to 79.2% about 8.8% improvement. The IR rate has dropped to 37.6% about14.4% improvement.
2. ERCP – implement Upfront Assessments for clients after-hours.	Ed Sosa	3/1/09	Contract approved on 2/2/09 to fund up-front assessments county-wide.
3. Adoptions – increase % of children adopted within 24 months to 30%.	Bill Thomas	6/1/09	As of 1/2/09 the percentage of children being adopted with 24 months has increased by .2%
4. KinGap – increase number of children in Kingap by 6%.	Michael Gray	6/1/09	New KinGap tracking report developed to allow each office to track progress towards their goal. As of 2/1/09 we have moved 573 youth into KinGap, which is 65% of our goal of 878.
5. Reduce number of Permanent Placement (PP) children by 10% from 5/1/08.	Mercedes Lopez	6/1/09	Goal was to reduce PP caseloads by 10% to 13,395. As of 1/1/09, PP caseloads = 13,485.
6. Reduce Generic caseload average from 26 to 24 cases.		6/1/09	As of 1/2/09 the goal was exceeded. The average = 23.19 cases.
7. Reduce ER caseload average from 24 to 22 referrals.		6/1/09	As of 1/2/09 the goal was exceeded. The average = 18.99 referral children.
8. Human Resources (HR) – hire 160 CSWs by 12/1/08. Maintain hiring of line staff to fill behind attrition rate.	Wanda Hazel	6/1/09	From 6/1/08 – 12/1/08: 289 CSWs were hired. As of 2/1/8, CSW vacancy is 3%.
Resources: 1. Hiring of social workers has continued and HR is keeping the staffing level at an all time high. 2. Training resources for the CPHL are adequate.			

3. Upfront assessment contracts approved by the Board of Supervisors on 2/2/09.
4. Various online, web-based reports are now available to managers for tracking caseload distribution within each office, KinGap progress, and caseload averages.

Dependencies:

1. Reduction of CPHL screen-in rates and IR rates is critical to reducing ER and Generic caseloads. Progress has not been adequate to realize significant drops in ER caseloads.
2. The implementation of up-front assessment contracts is an important aspect of ERCP detention reduction strategy.
3. The ability to continue to fill behind vacant CSW positions is critical to overall success in reaching goals.

Customer Benefits:

1. The lowering of caseloads will provide CSW staff more time to provide services in the front end.
2. The successful efforts by HR to maintain a high level of CSW staffing has contributed to the progress in caseload reduction.
3. Clients will receive timely assessments due to the recent approval of up-front assessment contracts.

Issues and Risks:

1. Contracts for upfront assessments approved on 2/2/09, however this does not allow sufficient time for full implementation by 6/1/09. Though it is unclear if access to up-front assessments will reduce ERCP detentions, clients will benefit from faster access to DMH services.
2. Any freeze on CSW hiring will be detrimental to continued progress in caseload reduction.
3. The effects of the dramatic economic downturn, coupled with the State's budget instability and recent freeze of child welfare payments, may result in increased child abuse and referrals to the CPHL.
4. Decreased or unavailable Temporary Aid to Needy Families (TANF) payments to vulnerable populations, including single parent families, may contribute to increased risk to children.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #15- Legislative Advocacy	
Start Date: November 1, 2008	
Sponsors: Miguel Santana, CEO Trish Ploehn, DCFS Marv Southard, DMH Sheila Shima, DMH	
Project Managers: Susan Rajlal, DMH Mitch Mason, DCFS Lesley Blacher, CEO	
Background: The Katie A. Strategic Plan Board Letter and Strategic Plan, approved by the Board of Supervisors on October 14, 2008, directed the Chief Executive Office (CEO) along with the Departments of Children and Family Services (DCFS) and Mental Health (DMH) to develop legislative, regulatory, and administrative proposals seeking greater flexibility from the State to maximize revenue reimbursement to the County, particularly in claiming Medi-Cal Early Periodic Screening, Diagnosis and Treatment (EPSDT) funds.	
Project Objective:	**Expected Operational Date:**
1. Incorporate Katie A. into the County's FY 2009-10 Legislative Platform.	11/1/08
2. Educate legislators on the importance of preserving Mental Health Service Act (MHSA) funds and in discussing some of the shortfalls/nuances of EPSDT funding.	2/1/09 – ongoing
3. Examine what cost efficiencies/cost neutral activities other jurisdictions have put into place with Medi-Cal funding.	In progress
Expected Outcomes: 1. Have a clearer understanding of Medi-Cal service eligibility and reimbursement guidelines for the provision of integrated mental health services in social service delivery models such as Wraparound. 2. Put proposals in place for State/Federal consideration to reduce the County's net county cost (NCC) for providing mental health services to Katie A. class and potential class members.	

Deliverables:	Project Lead(s):	Planned Timeline:	Status
1. Develop fact sheets for upcoming meetings with legislators to: • Educate legislators on the importance of preserving Mental Health Service Act (MHSA) funds incorporating LA County outcomes resulting from MHSA funding; and • Stress the importance for the State to clearly articulate EPSDT billable from reimbursable service activities within the Wraparound integrated service model.	Susan Rajlal Greg Lecklitner	2/4/09	Completed
2. Develop analysis determining whether a State Plan Amendment is required to increase the billing rate for DMH co-located staff/mental health providers beyond the capped State schedule of maximum allowances (SMA). Providers can provide Wraparound services and be adequately reimbursed for costs incurred (at a higher rate) to compensate for those activities that are not billable, i.e. completion of court reports.	Anita Lee	2/19/08	Completed
3. Develop Proposal for CMS inclusive of recommended enhanced rate structure for Wraparound Services, based on cost data collected for a period, along with developing regulations, which define eligibility criteria for receiving a higher reimbursement rate for Wraparound services. An earlier version of this proposal to be shared with the Special Master in the Katie A. State Case.	Anita Lee	3/31/10	In progress
4. Disaggregate non-billable from non-reimbursable service costs from the Wraparound Mental Health Service Activity Claiming Matrix to clearly delineate service activities that are not covered by Medi-Cal	Norma Fritsche	3/27/09	In progress

Resources:
There is existing staff.

Dependencies:
1. State budget cuts and revenue redirection, i.e. Proposition 63 MHSA funds; and
2. Impact of the Obama administration on the Centers for Medicare and Medicaid Services (CMS).

Customer Benefits:
1. A clearer understanding for counties concerning the State's position on Medi-Cal service eligibility and reimbursement for integrated/intensive mental health service provisions through service delivery models such as Wraparound.

Issues and Risks:
1. National/State budget crises will make it difficult to augment Medi-Cal funding; however, with the Obama administration, more progressive policies could be forthcoming from CMS.
2. The County will continue to work collaboratively with the Katie A. Advisory Panel and Plaintiffs' attorney in the State case to advance the interests of the County in exploring ways to maximize federal funding for Wraparound–like services and seeking ways to make the provision of such services easier for counties within existing Medi-Cal requirements to draw down.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #16- Training	
Start Date: January 1, 2009	
Sponsors: Susan Kerr, DCFS, Senior Deputy Director Olivia Celis, DMH, Deputy Director	
Project Managers: Mark Miller, DCFS Angela Shields, DMH	
Background: Consistent with the November 2006 order of the federal court and in concurrence with the Katie A. Advisory Panel, Los Angeles County has recognized the need for systemic improvements to better meet the mental health needs of children and families. To ensure identification of DCFS children's needs and that individualized, intensive home-based services are delivered, DCFS and DMH will jointly deploy training support and resources based upon the foundations of good practice – engaging families, effective teaming and coordination, thorough assessment of strengths and needs, individualized planning and effective interventions. Targeted training and learning objectives will support the implementation of screening and assessment protocols and the plan for a strengthened service delivery system.	
Project Objectives:	**Expected Operational Date:**
1. Joint Overview/Orientation Training (Core Practice Model, Values, Practice Principles, etc.)	3/17/09 – 4/29/08 – Belvedere/SFS 5/1/09 – Wateridge/Vermont 6/1/09 - Compton 7/1/09 - Palmdale/Lancaster
2. Training to Support Targeted Strategies for Resource Development and Process Change	In progress
3. Training to Support DMH / DCFS Specialized Functions	In progress
4. Training and Coaching to Support Implementation of Child and Family Teams (provider and public agency staff)	In progress
5. SABA Learning Management System (LMS)	In progress

Expected Outcomes:

1. Joint Overview/Orientation: Strengthened understanding, alignment and shared ownership/accountability (DMH/DCFS) with regard to key Katie A. components and initiatives at local level. Better understanding, integration and application of skills associated with the Core Practice Model/QSR supporting successful implementation and ongoing improvement.
2. Training to support targeted strategies:
   - Training supports the expansion and application of Team Decision-Making (TDM).
   - Training on Structured Decision Making (SDM) supports improved decision making at key decision points including the Child Protection Hotline to meet caseload reduction targets in DCFS.
   - Training to support implementation and expansion of Up-Front Assessments and the expansion of Multi-disciplinary Assessment Teams (MAT) for the timely assessment and linkage to service for referred children and families.
   - Training on key initiatives (Concurrent Planning, Permanency Partners Program, Family Finding/Engagement) to advance implementation of targeted strategies for improving timelines to permanency.
3. Training to support DMH / DCFS specialized functions, such as Katie A. Screening and Assessment components and infrastructure to insure prompt screening, assessment and linkage to key services. Supports CSAT, RMP, Mental Health Screening Tool, Referral Tracking System and other related policies and protocols.
4. Training and Coaching to support implementation of Child and Family Teams to support expansion of the provider base that delivers a Wraparound approach to Child and Family Teams and Intensive in-home based services.
5. Training supports practice change for line staff based on Core Practice Model/QSR; supported through coaching/mentoring model for skill application/development.
6. SABA Learning Management System (LMS) will streamline the attendance, feedback and tracking process for employee training.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Develop and provide joint overview/orientation training - DMH, DCFS, providers	Mark Miller Angela Shields	3/1/09	In progress - 8 regional office visits completed
2. Provide training to support targeted strategies – TDM, SDM, Concurrent Planning Re-Design, Visitation	Mark Miller Angela Shields Inter-University Consortium (IUC)	On-going	In progress Training is on-going to maximize caseload reduction efforts
3. Provide training to support Katie A. Plan components – CSAT, RMP, CANS, Consent, CFT, Referral Tracking	Mark Miller Angela Shields David Cantu	3/1/09	In progress

4. CFT/Wraparound training overview – public agency staff	IUC Sherman Mikle	4/1/09	In progress Curriculum under development
5. Core practice model/QSR in-depth practice training – public agency staff	IUC Mark Miller	5/1/09	In progress Curriculum under development
6. Implementing CFT through coaching and mentoring – provider staff	Sherman Mikle Shirley Robertson Angela Shields	5/1/09	In progress Contracts under development
7. SABA - Learning Management Systems (LMS)	Mark Miller Angela Shields	1/2/09	In progress

Customer Benefits:

1. DCFS and DMH staff will have a better understanding of the various initiatives relating to the Katie A. Settlement Agreement.
2. Public agency staff will have obtained the requisite skills to effectively implement the four primary provisions of Wrap: engagement/team preparation, initial plan development, implementation, and transition.
3. Provider staff will have on-going support in the implementation and expansion of Child and Family Teams through coaching and mentoring.

Resources:

1. Eight (8) CSA Is to provide direct training, planning, coordination, and delivery of training.
2. One (1) CSA II to provide operational oversight to the CSA I trainers; one (1) STC to provide clerical support.
3. The annual budget for training related purposes is approximately $1 million per year.

Dependencies:

1. Overview training relies upon the completion/finalization of the respective policies.
2. Procurement of consultants and hiring key staff will affect the deliverables.
3. Trainings based upon expansion time-frames and staff hiring for Wraparound providers.

Issues and Risks:

1. On-going participation by line-staff (DCFS/DMH) in the development of curriculum is essential to securing shared ownership of the plan.
2. Challenge of balancing multi-day skill-based training for line case carrying staff against demands of ongoing casework.

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County of Los Angeles
Departments of Children and Family Services and Mental Health
Katie A. Implementation Plan

PROJECT DATA SHEET	
Project Name: #17- Data Management	
Start Date: September 2008	
Sponsors: Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director	
Project Managers: Elaine Magnante-Music, DCFS Gary Puckett, DMH Ayanna McLeod, CEO	
Background: In response to the Katie A. Settlement Agreement, the County of Los Angeles, in concurrence with the Katie A. Panel, agreed to select and track a discrete set of data indicators for all class members to determine whether children are being systematically screened and assessed for mental health needs and, when appropriately identified, receive those services in a timely manner. In addition, data indicators that track safety, permanency, well-being, and mental health service expenditures monitored to evaluate Katie A. program implementation.	
Project Objective:	**Expected Operational Date:**
1. Identify data indicators to measure and monitor progress in the following: • Timeliness of Mental Health Screenings; • Assessment; • Referral to Service; • Provision of Treatment; • Duration of Service; • Mental Health Expenditures, and • Outcomes associated with the delivery of service – safety, permanency, and well-being.	In progress
2. Confirm selection of subset of Operational Efficiency, Safety, Permanency, Well-Being, and Mental Health Expenditure indicators and the development of benchmarks, operational definitions, and tracking intervals for exit criteria.	In progress

Expected Outcomes:

1. Development of a discrete set of data indicators that will monitor accountability and compliance with the terms of the Settlement Agreement.
2. Provide a means for evaluating the timeliness of children screened, assessed and linked to mental health services as needed.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
1. Development of Katie A. "Draft" Data Inventory	Ayanna McLeod	3/1/08	Completed
2. Finalize selection of data indicators and those identified as "Exit Condition" data indicators (see attached Data Inventory)	All	3/25/09	Completed
3. Finalize data descriptions and operationalize data definitions	Jennifer Eberle Norma Fritsche Cecilia Custodio Alan Weisbart	3/18/09	Completed
4. Build Referral Tracking System (RTS) to gather data	See PDS for RTS	See PDS for RTS	See PDS for RTS

Resources:

1. Chief Information Office Bureau has hired 2 staff positions to support the data project and CEO and DHR are providing additional support to expedite the hiring of the 3rd position.
2. DCFS has hired one (1) of five (5) Information Technology positions allocated through the Katie A. Strategic Plan and is aggressively advertising to fill the remaining positions.
3. Approximately $500,000 is allocated to hire consultants to act as Project Manager, Business Analyst and Application Developer over the DMH administered Katie A. database and associated cubes.

Dependencies:

1. DCFS will need to flag "Special Project" fields within CWS/CMS in the interim to track mental health services delivery.
2. DMH and DCFS to provide each other with data elements necessary for the incorporation into the Cognos Cube and CWS/CMS; which will assist in the tracking and monitoring of mental health service delivery and client level outcomes.
3. Hiring of key staff/expediting the procurement process for the consultants will affect the deliverables.

Customer Benefits:

1. Capacity to monitor and evaluate the timeliness and efficacy of mental health screening, assessment and service delivery, as well as programmatic outcomes related to the Katie A. Strategic Plan.

Issues and Risks:

1. SACWIS regulations and mental health/child welfare confidentiality provisions continue to remain an obstacle in data sharing between the departments of DCFS and DMH. When the federal court order directing the departments to share data expires, new agreement directives will need to be put in place to continue the sharing of this data between the two departments for planning and service coordination functions.

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KATIE A. DATA INVENTORY
03/12/2009

Issues To Be Determined:

- Data Measurement – point in time versus proxy class/entry cohort
- Operational definition for proxy class/entry cohort (timeframe to track calendar year versus fiscal year)
- Confirmation of selection of Operational Efficiency Indicators for Exit Criteria and development of benchmarks
- Selection of subset of Safety, Permanency, Well-Being, and Mental Health Service Expenditure Indicators to track as part of Exit Criteria; operational definitions; baselines/standards
- Selection of subset of informational indicators to track and standards
- Determination of which indicators should be tracked longitudinally and should any distinctions be made between variables capturing rates versus time-lags
- Determine tracking intervals for variables (both Exit and Informational)

DEMOGRAPHICS					
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Data Indicator Description**
1	Total number of active cases in DCFS	7		CWS/CMS	Includes voluntary, involuntary, in-home and out-of-home placements.
2	By Regional Office/SPA (number/percentage/total)	7		CWS/CMS	Refers to DCFS office with current case responsibility.
3	By placement type (number/percentage/total)	7		CWS/CMS	
4	By service component	7		CWS/CMS	FM, FR, PP
5	By case status	7		CWS/CMS	Voluntary vs. Court Cases
6	By rate classification level	7		CWS/CMS	
7	By age category	7		CWS/CMS	
8	By race/ethnicity	7		CWS/CMS	*(need to define race)*
9	By language spoken (child and family)	7		CWS/CMS	
10	By gender	7		CWS/CMS	
11	By placement location – by SPA	7		CWS/CMS	

OPERATIONAL EFFICIENCY – NEWLY DETAINED (ND)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Have newly detained (ND) children been screened within 30 days of case opening?	7		CWS/ CMS (SP)	✓	E	Newly detained children from new referrals converted into a case under a WIC 300 petition filing and placed out of home.
1a.	Date of initial case plan	7		CWS/ CMS		I	Use date Program Code change from ER to FR. - Information currently exists in CWS/CMS.
1b.	Date of referral to HUB			CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of referral to the HUB
1c.	CIMH mental health screening (positive/negative) and date	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1d.	Number/percent of ND children receiving positive/negative mental health screening	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1e.	DCFS Consent for Mental Health Services provided (parent, court, child, denied) and date	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track date consent was received from parent, court, child or denied
1f.	Number/percent of ND children for whom Consent for Services is provided	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube – DCFS has created a Special Projects field in CWS/CMS to track date consent was received
1g.	Date of EPSDT eligibility	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track “Medi-Cal Eligible” and the date that eligibility is established.
1h.	Number/percent of EPSDT eligible children who screen positive for mental health services (active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube using DCFS CIMH screen date and DCFS Benefits Establishment
1i.	Number/percent of ND children who screen positive for mental health services who are not EPSDT eligible (not active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS CIMH positive screen and Non-Medi-Cal eligible Special Project fields in CWS/CMS
2	Do ND children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question

OPERATIONAL EFFICIENCY – NEWLY DETAINED (ND)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
2a.	Number of days between positive screening and referral to DMH	7		CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH
2b.	Number of days between positive mental health screening and case opening	7		DMH Data Warehouse	✓	E	CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802
2d.	Number of days between case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse			
2e.	Number/percent of ND children receiving a mental health assessment	7		DMH Data Warehouse		I	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of ND children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		I	Clients diagnosed with an “included” diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those ND children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner?	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between positive CIMH/MHST screening and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date positive DCFS screening and date of an initial service code (therapy, rehab, group)
4b.	Number of days between DMH open episode date and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date of DMH episode opening and date of an initial service code
4c.	Number of days between face to face assessment contact and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date of first 90801/90802 and date of an initial service code

OPERATIONAL EFFICIENCY – NEWLY DETAINED (ND)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
4d.	Unique Number/percent of ND children receiving intensive mental health services	7		DMH Data Warehouse		I	Number of children enrolled in FSP, SOC, ITFC and Intensive In-Home which includes: MST, MTFC, CCSP, and Wraparound plans
4e.	Number of days between intensive mental health services start and end date: by termination reason	7		DMH Data Warehouse		I	First date of claim and episode closure for kids in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans; referral out codes could provide data for termination
4f.	Unique Number/percent of ND children receiving basic mental health services	7		DMH Data Warehouse		I	Number of children without claims in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans for 30 days
4g.	Number of days between basic mental health services start and end date: by termination reason	7		DMH Data Warehouse		I	First date of claim and episode closure as long as the claim is not in one of the above intensive plans; referral out codes could provide data for termination

OPERATIONAL EFFICIENCY – NEWLY DETAINED/MAT (ND-MAT)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
2	Do ND-MATchildren who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question
2a.	Number of days between positive mental health screening and referral to DMH for MAT assessment			CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH (MAT/Co-located)
2b.	Number of days between positive mental health screening and MAT case opening			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and MAT face-to face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802

OPERATIONAL EFFICIENCY – NEWLY DETAINED/MAT (ND-MAT)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
2d.	Number of days between MAT case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse		I	Date of first claim to MAT plan (i.e. opening of MAT services) and date of the first 90801 (psychiatric diagnostic interview) or 90802 (interactive psychiatric diagnostic interview using play equipment, physical devices, or other non-verbal mechanism of communication) procedure codes for clients using the MAT-DMH Plan
2e.	Number/percent of ND-MAT children receiving a mental health assessment	7		DMH Data Warehouse		I	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of ND-MAT children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		I	Clients diagnosed with an “included” diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those ND-MAT children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner?	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between date of positive CIMH/MHST screening and initial mental health treatment delivery for MAT cases	7		DMH Data Warehouse		I	Date of first 90801 and date of a initial service code (therapy, rehab, group)
4b.	Number of days between opening of a MAT DMH episode date and initial mental health treatment delivery			DMH Data Warehouse		I	Date of DMH MAT episode opening and date of an initial service code
4c.	Number of days between MAT face to face assessment contact and initial mental health treatment delivery			DMH Data Warehouse		I	Date of first 90801/90802 and date of an initial service code

OPERATIONAL EFFICIENCY – NEWLY OPENED/NON-DETAINED (NOD)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Have newly opened/non-detained (NOD) children been screened within 30 days of case opening?	7		CWS/ CMS (SP)	✓	E	Newly Opened/Non-detained = Children from new referrals converted into a case under a Voluntary Family Maintenance (VFM), Voluntary Family Reunification (VFR), or court-ordered Family Maintenance (FM) case plan.
1a.	Date of initial case plan	7		CWS/ CMS		I	Use date Program Code change from ER to FM - Information currently exists in CWS/CMS.
1b.	CIMH mental health screening (positive/negative) and date	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1c.	Number/percent of NOD children receiving positive/negative mental health screening	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1d.	DCFS Consent for Mental Health Services provided (parent, court, child, denied) and date	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track date consent was received from parent, court, child or denied
1e.	Number/percent of NOD children for whom Consent for Services is provided	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube – DCFS has created a Special Projects field in CWS/CMS to track date consent was received
1f.	Date of EPSDT eligibility	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track “Medi-Cal Eligible” and the date that eligibility is established.
1g.	Number/percent of NOD children who screen positive for mental health services who are EPSDT eligible (active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube using DCFS CIMH screen date and DCFS Benefits Establishment
1h.	Number/percent of NOD children who screen positive for mental health services who are not EPSDT eligible (no active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS CIMH positive screen and Non-Medi-Cal eligible Special Project fields in CWS/CMS
2	Do NOD children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question

OPERATIONAL EFFICIENCY – NEWLY OPENED/NON-DETAINED (NOD)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
2a.	Number of days between positive screening and referral to DMH for assessment	7		CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH (Co-located)
2b.	Number of days between positive mental health screening and case opening	7		DMH Data Warehouse	✓	E	CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802
2d.	Number of days between case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse			
2e.	Number/percent of NOD children receiving a mental health assessment	7		DMH Data Warehouse		I	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of NOD children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		I	Clients diagnosed with an “included” diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those NOD children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner?	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between positive CIMH/MHST screening and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date positive DCFS screening and date of an initial service code (therapy, rehab, group)
4b.	Number of days between DMH open episode date and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date of DMH episode opening and date of an initial service code

OPERATIONAL EFFICIENCY – NEWLY OPENED/NON-DETAINED (NOD)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
4c.	Number of days between face to face assessment contact and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date of first 90801/90802 and date of an initial service code
4d.	Unique Number/percent of NOD children receiving intensive mental health services	7		DMH Data Warehouse		I	Number of children enrolled in FSP, SOC, ITFC and Intensive In-Home which includes: MST, MTFC, CCSP, and Wraparound plans
4e.	Number of days between intensive mental health services start and end date: by termination reason	7		DMH Data Warehouse		I	First date of claim and episode closure for kids in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans; referral out codes could provide data for termination
4f.	Unique Number/percent of NOD children receiving basic mental health services	7		DMH Data Warehouse		I	Number of children without claims in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans for 30 days
4g.	Number of days between basic mental health services start and end date: by termination reason	7		DMH Data Warehouse		I	First date of claim and episode closure as long as the claim is not in one of the above intensive plans; referral out codes could provide data for termination

OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Have existing/open case (EO) children been screened within 30 days of case opening?	7		CWS/ CMS (SP)	✓	E	Existing = Open cases under all court-ordered or Voluntary FM, FR, and PP case plans.
1a.	CIMH mental health screening (positive/negative) and date	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1b.	Number/percent of EO children receiving positive/negative mental health screening	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1c.	DCFS Consent for Mental Health Services provided (parent, court, child, denied) and date	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track date consent was received from parent, court, child or denied

OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1d.	Number/percent of EO children for whom Consent for Services is provided	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube – DCFS has created a Special Projects field in CWS/CMS to track date consent was received
1e.	Date of EPSDT eligibility	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track "Medi-Cal Eligible" and the date that eligibility is established.
1f.	Number/percent of EPSDT eligible EO children who screen positive for mental health services (active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube using DCFS CIMH screen date and DCFS Benefits Establishment
1g.	Number/percent of EO children who screen positive for mental health services who are not EPSDT eligible (not active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS CIMH positive screen and Non-Medi-Cal eligible Special Project fields in CWS/CMS
2	Do EO children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question
2a.	Number of days between positive screening and referral to DMH for assessment	7		CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH (Co-located)
2b.	Number of days between positive mental health screening and case opening	7		DMH Data Warehouse	✓	E	CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802
2d.	Number of days between case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse			

OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
2e.	Number/percent of EO children receiving a mental health assessment	7		DMH Data Warehouse		I	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of EO children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		I	Clients diagnosed with an "included" diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those EO children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between positive CIMH/MHST screening and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date positive DCFS screening and date of an initial service code (therapy, rehab, group)
4b.	Number of days between DMH open episode date and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date of DMH episode opening and date of an initial service code
4c.	Number of days between face to face assessment contact and initial mental health treatment delivery	7		DMH Data Warehouse		I	Date of first 90801/90802 and date of an initial service code
4d.	Unique Number/percent of EO children receiving intensive mental health services	7		DMH Data Warehouse		I	Number of children enrolled in FSP, SOC, ITFC and Intensive In-Home which includes: MST, MTFC, CCSP, and Wraparound plans
4e.	Number of days between intensive mental health services start and end date: by termination reason	7		DMH Data Warehouse		I	First date of claim and episode closure for kids in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans; referral out codes could provide data for termination
4f.	Unique Number/percent of EO children receiving basic mental health services	7		DMH Data Warehouse		I	Number of children without claims in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans for 30 days

OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
4g.	Number of days between basic mental health services start and end date: by termination reason	7		DMH Data Warehouse		I	First date of claim and episode closure as long as the claim is not in one of the above intensive plans; referral out codes could provide data for termination

SAFETY							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Percent of referred children by disposition type	P		CWS/CMS		I	• Includes: Evaluated out, Unfounded, Inconclusive, Substantiated, Not Disposed • Excludes referrals with disposition type "entered in error" and with no referral response type.
2	Percent of open cases that have had 2 or more substantiated referrals during the last 12 months	P		CWS/CMS	DCFS Benchmark - 5.6%	E	• 2 or more referrals on active cases for the last 12 months from the last day of the reporting month • Number of active cases is based on active cases on the last day of each reporting month
3	No maltreatment in foster care – Of all children served in foster care during the year, what percent were not victims of a substantiated maltreatment allegation by a foster parent/facility staff member?	P		CWS/CMS	National standard - 99.58%	E	Percentage of all children served in foster care, were not victims of a substantiated maltreatment allegation by a foster parent of facility staff member.
4	No recurrence of maltreatment within 6 months – after substantiated referral	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 94.6%	E	Percentage of children who do not experience repeat maltreatment during the 6 month period that followed the initial substantiated abuse report.

SAFETY							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
5	Percent of children enter foster care within 12 months of receiving Family Maintenance (FM) Services	P		CWS/CMS		I	• Number of FM children removed is those who were removed from the home of their parents within 12 months of receiving FM services. • Number of children for the reporting month is the number of children who received FM services during each of the reporting months.

PERMANENCY							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Median length of stay for children in foster care (out-of-home placement)	P		CWS/CMS	DCFS Benchmark - 516 days	E	• Number of children in placement is those who were actively in out-of-home placement as of the last day of the reporting months. o Excludes- Guardian homes, adoptive placement, non-foster care placements, kin-gap, probation, private adoption, and revenue enhancement cases. • Median days based on the most recent removal date and last day of each reporting month (report date).
2	Number of children in congregate care settings	P		CWS/CMS		I	• Total number of children in congregate care settings (children placed in group homes) who are actively in congregate care placement as of the last day of the reporting month. • Total number of children in group homes will be broken down by RCL (Rate Contract Level)

PERMANENCY							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
3	Number of children exiting foster care by termination reason type	P		CWS/CMS		I	• Based on Placement Episode Termination reason type. • Excludes Placement episodes that are 5 days or less.
4	Reunification within 12 months – Of all children discharged from foster care to reunification during the year who had been in foster care for 8 days or longer, what percent were reunified in less than 12 months from the date of the latest removal from home?	P/F		CWS/CMS	National standard - 75.2%	E	Percentage of children discharged to reunification within 12 months of removal.
5	Adoption within 24 months –Of all children discharged from foster care to a finalized adoption during the year, what percent were discharged in less than 24 months from the date of the latest removal from home?	P/F		CWS/CMS	National standard - 36.6%	E	Percentage of children adopted within 24 months of removal.
6	Reentry following reunification – Of all children discharged from foster care to reunification during the year, what percent reentered foster care in less than 12 months from the date of the earliest discharge to reunification during the year?	P/F		CWS/CMS	National standard - 9.9%	E	Percentage of children reentering foster care within 12 months of a reunification discharge.

PERMANENCY							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
7	Children with 2 or less placements in less than 12 months in care	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 86.0%	E	• The percentage of children with 2 or fewer placements in foster care for 8 days or more, but less than 12 months; • Time in care is based on the latest date of removal from home; • The denominator is the total number of children who have been care for at least 8 days but less than 12 months; and • The numerator is the count of these children with 2 or fewer placements.
7a.	Within 12 – 24 months	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 65.4%	E	• The percentage of children with 2 or fewer placements in foster care for at least 12 months, but less than 24 months; • Time in care is based on the latest date of removal from home; • Denominator = the total number of children who have been in care for at least 12 months and less than 24 months; and, • Numerator = the count of these children with 2 or fewer placements
7b.	At least 24 months	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 41.8%	E	• The percentage of children with two or fewer placements in foster care for 24 months or more; • Time in care is based on the latest date of removal from home; • The denominator is the total number of children who have been in care for 24 months or more; and • The numerator is the count of these children with 2 or fewer placements.

WELL-BEING							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark / National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Children in out-of-home care per 1,000			TBD		I	• County's out-of home care rate for a given year is computed by dividing the County count of children in foster care by the County's child population and multiply by 1,000. • Out-of-home care rates are based on children under the age of 18; therefore, they do not directly correspond to the total out-of-home care rates.
2	Number of children placed w/in 10 miles of home (from which they were detained - excluding relatives) and in excess of 10/20/30 or more miles)	P		CWS/CMS		I	• Examines the distance, in miles, between a child's removal home address and the child's first placement address for all children who are still I care 12 months after entry.
3	Siblings placed together in foster care	P		CWS/CMS		I	• Percent of sibling groups in foster care who are placed with some or all of their siblings: o Identified breakup of siblings into multiple placement home; o Breakout by placement homes and sibling groups; o Includes family count and child count; o Siblings are determined by a 7 digit serial number; and o Placement homes are determined by unique placement home records.

WELL-BEING							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark / National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
4	Number/percent of runaway children	P		CWS/CMS		I	• Number of outstanding runaway children as of the last day of reporting month in the out-of-home care population. • Percent of runaway children o The denominator is the number of runaway children/The numerator is the total number of children in the out-of-home care population.
5	Children in County who receive services from DMH/number of children served by DCFS and receive DMH mental health services - in County/out of County	P		DMH Data Warehouse		I	DMH to identify “in-County/out-of-County” data elements and insure they are in Data Warehouse/Cognos Cube.
6	Number/percentage of children with psychiatric hospitalizations	P		DMH Data Warehouse		I	DMH to identify Provider & Reporting Unit number for calculation.
7	Number/percentage of children entering the juvenile justice system	7		CWS/CMS		I	• Number of children in out of home care for the reporting month whose placement episode closure reason was incarcerated. • Percent of children entering juvenile justice system: o Denominator is the number of children in out of home care for the reporting month whose placement episode closure reason was incarcerated. o Numerator is the total number of children who had placement episode closure during the reporting month.

MENTAL HEALTH SERVICE EXPENDITURES							
	Data Indicator	**Category**	**Tracking Intervals**	**Data Source**	**Benchmark/ National Standard**	**Context: (E)xit or (I)nfo**	**Data Indicator Description**
1	Total expenditures by fiscal year	C		DMH Data Warehouse		I	Note: For all indicators listed below, it is important to keep in mind that different services have different reimbursement rates (i.e. outpatient therapy costs less than a day in an inpatient unit)
2	Total units of mental health service by fiscal year	C		DMH Data Warehouse		I	
3	Total expenditures by service category (day services, inpatient, outpatient)	C		DMH Data Warehouse		I	
4	Total expenditures and units of service by place of service(POS)	C		DMH Data Warehouse		I	
5	Total expenditures by gender	C		DMH Data Warehouse		I	
6	Total expenditures by age group	C		DMH Data Warehouse		I	
7	Total expenditures by SPA of origin	C		DMH Data Warehouse		I	DCFS to provide DMH with SPA of origin
8	Total expenditures and units of services by SPA of treating provider	C		DMH Data Warehouse		I	

Category Codes:
P: Catherine Pratt Indicators
7: Big Seven Indicators
F: CFSR Indicators
C: Cognos Cube

Operational Efficiency Codes:
ND: Newly Detained
NOD: Newly Opened/Non-Detained
EO: Existing Open

PROJECT DATA SHEET	
Project Name: #18- Qualitative Service Review (QSR)	
Start Date: 3/1/09	
Sponsors: Olivia Celis-Karim, DMH, Deputy Director Lisa Parrish, DCFS, Deputy Director	
Project Managers: Marilynne Garrison, DCFS Brian Bruker, DCFS Norma Fritshe, DMH	
Background: A Qualitative Service Review (QSR) is one of the components of the County's exit criteria from the Katie A. class action lawsuit. A three-pronged approach is proposed to exit from the lawsuit consisting of: 1) successful adoption by the Board of Supervisors/Court of a meaningful strategic plan; 2) passing score on a QSR; and 3) acceptable progress on a discrete set of data indicators. The QSR will be used to evaluate the quality of practice through child status and system performance indicators, based on this practice of evaluation developed by the Child Welfare Policy and Practice Group as well as the actual instrument developed by Human Systems and Outcomes, Inc. Los Angeles DCFS and DMH staffs visited Utah in November 2008 to observe their QSR process, and are planning to implement a QSR process in late 2010 as part of our exit criteria to document system performance improvement under the Katie A. Strategic Plan.	
	Expected Operational Date:
1. Phase I: Develop parameters for a QSR, identify staff responsible for development of a protocol, identify training resources and funds, identify and train lead reviewers, and plan for implementation.	7/1/10
2. Phase II: Begin phased implementation of QSR by DCFS regional office in September 2010 (one office per month, skipping July, August and December each year), finishing the 18 DCFS regional offices in July 2012, with a final report issued by December 15, 2012.	9/1/10 – 12/15/12
3. Phase III: Re-review any offices with unacceptable levels of performance, complete and issue follow-up report by December 15, 2013.	12/15/13

Expected Outcomes:

1. Phase I: A QSR protocol which coherently and efficiently integrates this new process within the Quality Improvement/Quality Assurance framework by: 1) clearly delineating obligations and work flow at DCFS; developing a trained infrastructure to fulfill the obligations of the QSR, roll-out a plan; and supervise and conduct reviews and produce follow-up reports.
2. Phase II: Initiate a Countywide rollout of QSR using a sample of cases from each DCFS office, produce QSR reports for each office, and a final report on QSR outcomes and successes or opportunities for program improvement strategies.
3. Phase III: Follow-up reviews will be conducted at offices with unacceptable levels of performance and a follow-up report will be developed.

Deliverables:	**Project Lead(s):**	**Planned Timeline:**	**Status**
Phase I			
1. Hire a CSA II at DCFS to head a new Quality Improvement Section.	Marilynne Garrison	3/1/09	Completed
2. CSA II to explore existing QSR processes in other jurisdictions to identify promising protocols	Brian Bruker	6/1/09	In progress
3. Identify funds available to support QSR training and consultation from other jurisdictions	Brian Bruker	7/1/09	In progress
4. Procure consultation Services form HSO and other jurisdictions to assist with QSR start up activities	Brian Bruker	9/1/09	Pending
5. Create protocol, tools and identify roles/responsibilities for implementation	Brian Bruker	4/1/10	Pending
6. Create roll-out plan for implementation, and purchase consulting resources to conduct reviews	Brian Bruker	5/1/10	Pending
7. Identify county staff to collaborate in reviews	Brian Bruker	7/1/10	Pending
Phase II			
1. Complete reviews of three (3) DCFS offices	Brian Bruker	12/1/10	Pending
2. Issue preliminary findings from first three (3) reviews	Brian Bruker	1/15/11	Pending
3. Complete reviews of six (6) more DCFS offices	Brian Bruker	7/1/11	Pending
4. Issue preliminary findings for all eight (8) offices	Brian Bruker	9/15/11	Pending

5. Complete reviews of nine (9) final DCFS offices	Brian Bruker	7/1/12	Pending
6. Issue preliminary findings for all eighteen (18) DCFS offices	Brian Bruker	9/15/12	Pending
7. Issue final report on all eighteen (18) DCFS offices	Brian Bruker	12/15/12	Pending
8. Re-review any offices with unacceptable levels of performance, complete and issue follow-up report (can do nine [9] offices in one year, two year cycle to do all eighteen [18] offices)	Brian Bruker	12/15/13	Pending

Resources:

1. Existing staff at DCFS to support development of the protocols, tools and implementation plan.
2. Staffing at DCFS to plan and schedule meetings and reviews for individual offices, and to supervise and conduct reviews, focus groups and interviews.
3. $1.5 million budgeted in FY 2010-11 for costs of QSR. Will propose $300,000 from FY 2008-09 savings be used to conduct pre-implementation activities in consisting of:
   - Contract for a customized QSR instrument that meets the needs of Los Angeles County;
   - Pilot test the instrument and make any refinements needed; and
   - Identify, train, and certify qualified reviewers to conduct the administration of the reviews.

Dependencies:

1. Phase I: Funding for purchase, training and consultation on QSRs from outside jurisdictions.
2. Phase I: Other staff to support proposed DCFS QI/QA Manager, Brian Bruker in creating protocol and implementation plan.
3. Phase II: Successful training on and roll-out of CSAT, MAT, and CFTs for the regional offices.
4. Phase II: Successful implementation of screening, assessment and service linkage strategies in the offices.
5. Phase III: Successful completion of Phase II by December 2012.

Issues and Risks:

1. No resources identified in Katie A. Strategic Plan budget, proposed budget request currently under development.

PROJECT TEAM MEMBERS

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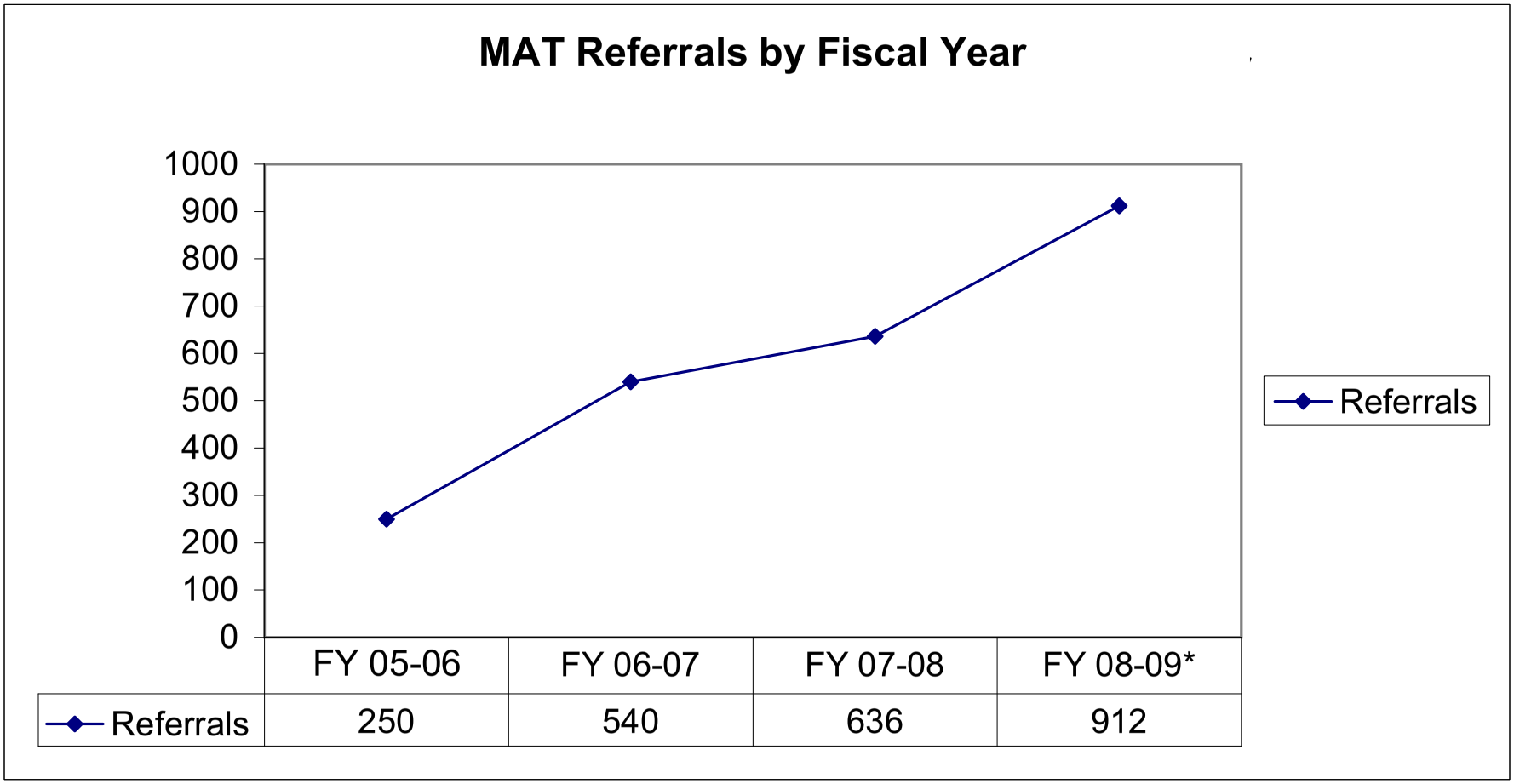
Attachment B



Data Source: DCFS MAT Referral and Completion logs through June 2008 and DMH Logs from July 2008 to Jan. 2009
Created by: Laura Andrade, Ph.D., MAT Program Manager
Report Date: March 18, 2009
* FY 2008-09 is current through Jan. 2009

Attachment C

Wraparound Vignettes for Tier I and Tier II

1. Example of a referral that would be appropriate for Tier I Wraparound

An example of a Tier I child (i.e., a child that is in or at imminent risk of placement in a RCL 10 or above) would be **M.** -- a 16-year-old girl who was sexually abused as a child and has been in the custody of DCFS since she was 8 years old. The whereabouts of her father is unknown and her mother is in prison related to a history of chronic substance abuse. She has had multiple foster and group home placements (15 in total) and three hospitalizations. She has a history of depression, poly substance abuse, stealing, prostitution and self-mutilating behavior. **M.** is currently placed in a RCL-12 and her CSW is making a Tier I Wraparound referral in order to facilitate her safe and successful return to the community and the home of a recently identified family member.

Below are examples of Tier I Wraparound type interventions for a youth like M.

Based on the presenting strengths of M and the relative care giver, the other members of the Child and Family Team (CFT) and the CSW, the team would create an individualized Plan of Care that would pair strengths with the identified underlying needs that are driving M's behavior. Those could include, but are not limited to:

1. Providing individual therapy, such as trauma-focused cognitive behavior therapy, for M related to her history of abuse.
2. Providing therapeutic behavioral services in the relative's home to assist M in transitioning to her new environment
3. Providing a parent partner to work with the relative caregiver, who may not understand the needs of M.
4. Providing linkages to family therapy, as needed.
5. Providing educational support to get back into a public school.
6. Developing a process, with the CFT, to understand the underlying needs behind the self destructive behavior, address triggers and develop 24/7 crisis response plans.
7. Developing strategies that pair M's strengths and needs to create successive approximation opportunities for growth and "seeing there is another way."
8. Providing flex funding to support those activities that are not covered by other funding streams. For example, M loves to do hair and has aspirations of being a hair stylist. The team would create an opportunity for M to practice and refine her skills by either paying for her to get additional schooling, or work with a local beauty shop to allow M to practice, or earn some money.
9. Providing housing support for the relative caregiver in caring for M. This may look like anything from paying rent for a larger apartment for a short period of time to buying an additional bed.

2. Example of a referral that would be appropriate for Tier II Wraparound

An example of a Tier II child (i.e., a DCFS child that has EPSDT and is experiencing intensive mental health needs that are impacting their educational and social functioning) is **J.** -- a 10-year-old boy who has recently come to the attention of DCFS after being removed from his mother's care, along with several siblings, due to neglect. He has a history of multiple school suspensions, running away and nocturnal enuresis. He has been living with his aunt and uncle for six months, but is having difficulty adjusting and his behavior has been escalating since his mother had a set back at her in-patient drug treatment program. **J**. has been in outpatient, individual therapy for five months with little progress and was hospitalized recently after stating that he wanted to kill himself. His CSW has made a referral to Tier II Wraparound in order to save **J'**s placement with his aunt and uncle and facilitate his return to mother following her successful completion of her drug treatment program.

Below are examples of Tier II Wraparound type interventions for a youth like J.

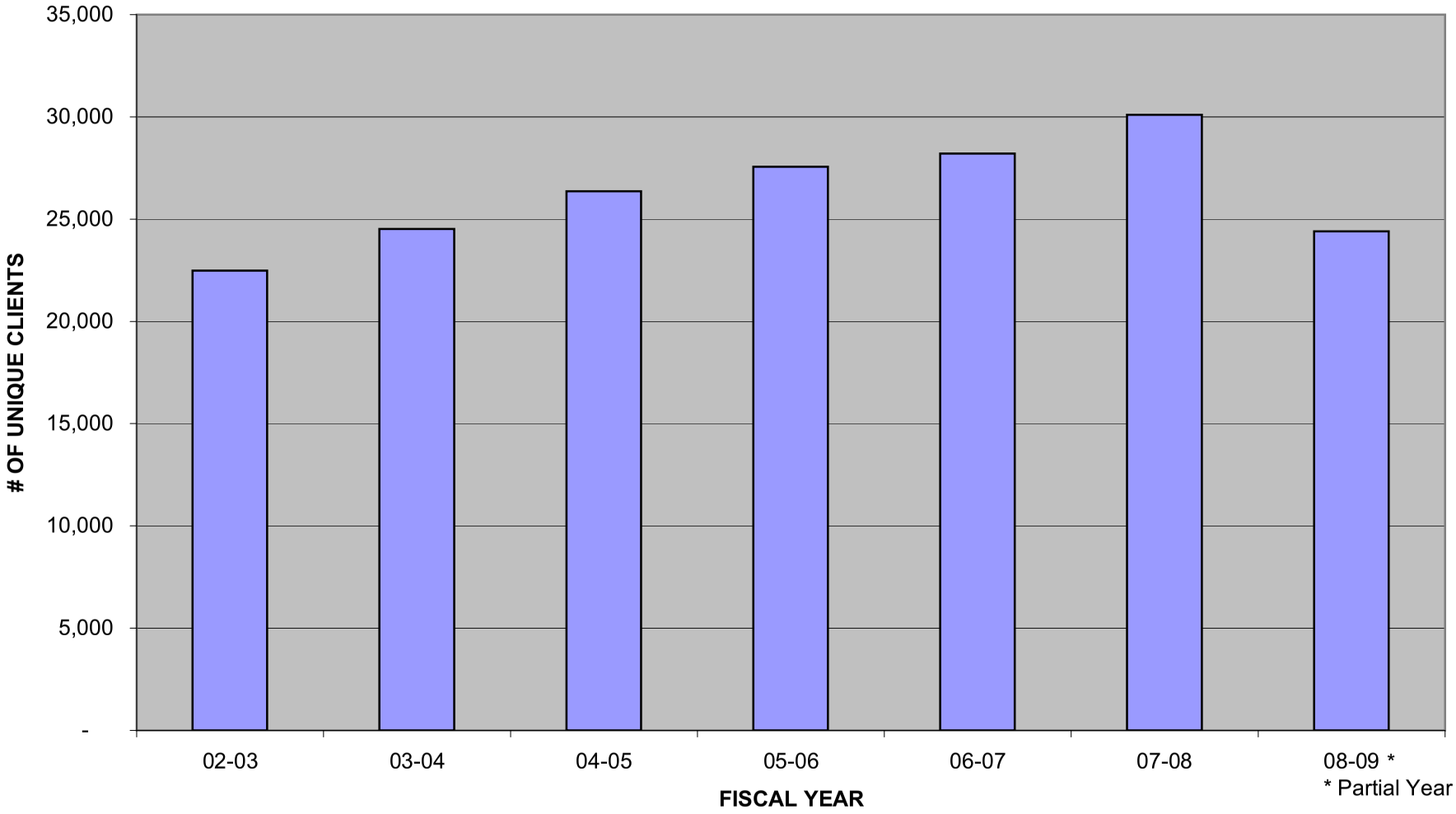
Based on the presenting strengths of J and his aunt and uncle, the other members of the Child and Family Team (CFT) and the CSW, the team would create an individualized Plan of Care that would pair strengths with the identified underlying needs that are driving J's behavior. Those could include, but are not limited to:

1. Providing intensive in-home treatment, including mental health and rehabilitative services for J.
2. Providing a parent partner to work with the aunt and uncle, who may not fully understand the needs of J.
3. Provide family therapy for J and his mother upon her return from drug treatment.
4. Providing educational support, in the form of mentoring and tutoring, to keep J in school.
5. Developing a process, with the CFT, to understand the underlying needs behind the self destructive behavior, address triggers and develop 24/7 crisis response plans.
6. Developing strategies that pair J's strengths and the needs to create successive approximation opportunities for growth and "seeing there is another way."
7. Working with J's mom to provide outreach and support.

Attachment D

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

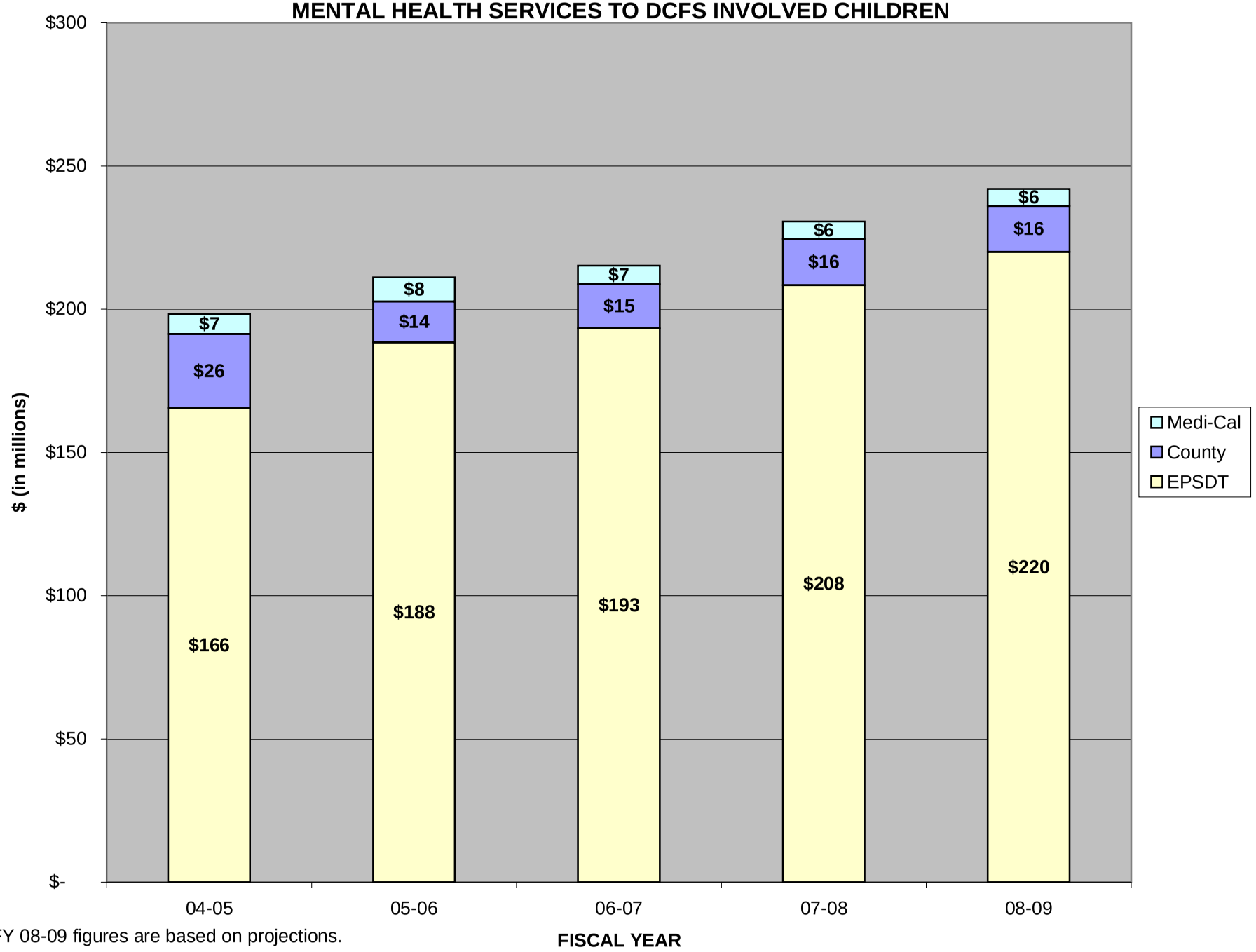
MENTAL HEALTH SERVICES FOR DCFS INVOLVED CHILDREN AND YOUTH



Attachment E

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES TO DCFS INVOLVED CHILDREN



*FY 08-09 figures are based on projections.

COUNTY OF LOS ANGELES

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Director

ROBIN KAY, Ph.D.
Chief Deputy Director

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DEPARTMENT OF MENTAL HEALTH

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Reply To: (213) 738-4601
Fax: (213) 386-1297

June 30, 2009

TO: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: Marvin J. Southard, D.S.W.
Director of Mental Health

Patricia S. Ploehn, L.C.S.W.
Director, Children and Family Services

SUBJECT: **KATIE A. QUARTERLY STATUS REPORT**

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003)
- Enhanced Specialized Foster Care Mental Health Services Plan (2005)
- Findings of Fact and Conclusions of Law ordered by Federal District Court Judge Howard Matz (2006)
- Health Management Associates Report (2007)
- Katie A. Corrective Action Plan (2007)

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

- Mental health screening and assessment
- Mental health service delivery
- Funding of services
- Training
- Caseload reduction
- Data/tracking of indicators
- Exit criteria and formal monitoring plan

The Strategic Plan and accompanying Board Letter directed the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS) to inform your Board of any revisions to the implementation of the Strategic Plan by March 2009, and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan, this report will also describe any significant deviations from the planning described in those documents.

The Departments have been directed to conduct an annual assessment in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement. In the interim, quarterly reports will be submitted on implementation activities by June 30, 2009 and September 30, 2009.

The first update was provided to your Board on March 27, 2009 as requested and this memo will serve as the second update on our progress in implementing the Strategic Plan.

Implementation Support Activities

A number of activities were conducted during this period to support the implementation of the Strategic Plan.

- Dr. Charles Sophy, DCFS Medical Director, Adrienne Olson, DCFS Katie A. Division Chief, Olivia Celis, DMH Deputy Director, and Greg Lecklitner, DMH Child Welfare Division District Chief, have completed their Katie A. Strategic Plan presentations in all 18 DCFS regional offices, providing an overview of the Strategic Plan's basic elements and engaging in dialogue with regional office staff regarding implementation issues. Planned visits remain for staff in Countywide programs, such as Adoptions and Medical Case Management Services.

- This same leadership team also met with DMH contract providers, the Association of Community Human Service Agencies (ACHSA), dependency court

bench officers, and attorney representatives to discuss the Katie A. Strategic Plan during this time period.

- Ongoing workgroup meetings are taking place across 18 major activity domains associated with the Strategic Plan and the progress of these workgroups is being documented in individual Project Data Sheets, which were attached in the last quarterly report.

- DCFS has now hired 58 of the 61 positions allocated for fiscal year (FY) 2008-09, and DMH has hired 2 of the 3 positions allocated for this same time period and has identified a candidate to hire for the final position.

- Just this month, Department representatives participated in a two-day meeting with the Katie A. Advisory Panel discussing training activities, data collection, Treatment Foster Care, and exit criteria.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Strategic Plan, are described below.

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and, if screened positive for mental health needs, assessed for mental health services. Nine Project Teams comprise the Screening and Assessment component of the Strategic and Implementation Plans as follows: 1) Medical Hubs; 2) Coordinated Services Action Team (CSAT); 3) Multidisciplinary Assessment Team (MAT); 4) Referral Tracking System (RTS); 5) Consent/Release of Information; 6) Benefits Establishment; 7) D-Rate; 8) Team Decision-Making (TDM) and Resource Management Process (RMP); and 9) Specialized Foster Care (SFC). Significant progress continues to be made by each of these project teams.

Medical Hubs: As of February 2009, 69 percent of newly detained children received an initial medical examination at a Medical Hub. A comprehensive plan has been developed to ensure 100 percent of the newly detained population is served by the Medical Hubs. The opening of the Satellite Medical Hub in El Monte on June 15, 2009 will serve the eastern part of Los Angeles, significantly reducing travel time for many caregivers. Soon to be released Medical Hub policy will include mandatory timeframes for submission of the Medical Hub Referral Form. Subsequent to the policy's release, a letter from the DCFS Director and Medical Director will be delivered to all DCFS staff mandating the referral of all newly detained children to a Medical Hub for medical and forensic evaluations. In accordance with the rollout of the CSAT and RTS in each office, Medical Hub referrals will be tracked to ensure compliance with the mandate.

Additionally, a web-based medical records system called E-mHub will allow the Medical Hub referrals to be submitted from DCFS to the Medical Hubs electronically as well as health and mental health information. Finally, a detailed review of each Medical Hub's capacity was completed in April 2009. A proposal to enhance Medical Hub capacity has been developed and is under review to determine the most feasible method for funding.

CSAT: On May 1, 2009, CSAT was implemented in Service Planning Area (SPA) 7 (the Belvedere and Santa Fe Springs offices). Training to support implementation in SPA 6 (the Compton, Wateridge and Vermont Corridor offices) is currently underway, with the official kickoff scheduled to occur on August 1, 2009. SPA 1 (Lancaster and Palmdale offices) will implement CSAT on September 1, 2009. By September 2009, all Phase I offices will have implemented CSAT and will begin hiring 20 additional staff to support the CSAT process in the Phase II offices scheduled to begin in January 2010. It is important to note that the 20 positions, originally budgeted to be hired in July 2009, will be hired in a more staggered approach over the fiscal year three months prior to CSAT implementation in those offices. DCFS expects to have full implementation of CSAT in all offices by December 31, 2010.

MAT: Experienced MAT operations in SPAs 3 and 6 are referring between 80-90 percent of all the eligible MAT cases for a MAT assessment, whereas newly implemented MAT operations in SPAs 1 and 7, which began in January of this year, are referring between 50-60 percent of all the eligible MAT cases as additional provider capacity is developed. During the period of time between July 2008 and April 2009, 1,405 children were referred to MAT and 1,180 MAT assessments were completed. During the month of April 2009, a total of 164 children were referred to MAT and 137 MAT assessments were completed.

MAT implementation has been limited in SPA 1 due to capacity issues in the SPA 1 area. SPAs 2, 4 and 8 will implement MAT in June 2009, following the training of the MAT providers, and SPA 5 will implement shortly thereafter. Once MAT is implemented in these SPAs, MAT referral capacity will build slowly consistent with expanding MAT provider capacity.

RTS: The RTS became operational on May 1, 2009 in the SPA 7 offices. DCFS and DMH continue to make refinements to the system as the need for additional business rules are identified. Use of the tracking system will expand in conjunction with the implementation of CSAT in each DCFS office. Beginning May 30, 2009, the Departments were directed to produce detailed summary data reports to your Board on a monthly basis. The next report will be submitted in June and will report on the screenings, referrals and linkages to mental health services that occurred for newly opened and existing cases in SPA 7 offices between May 1 – 31, 2009.

Consent/Release of Information: DCFS and DMH, in concert with their respective County Counsels, have developed procedures and forms to provide consent for mental

health services for referred children as well as the authorization to release protected health information for purposes of the child's care and coordination of services. Finalization of these procedures and forms is imminent, once concurrence has been obtained from the children's and parent's attorney groups.

Benefits Establishment: A process for benefits determination for all new and existing cases has been established in support of CSAT implementation.

D-Rate: In addition to the D-rate program's continued work to review and ensure mental health services for at least 90 percent of D-rate children, the duties of the DCFS D-rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning and service coordination for other high-need children.

TDM/RMP: Eight TDM facilitators were hired in the last quarter, now totaling 84 facilitators available at DCFS to coordinate TDMs and RMPs. DCFS also mandated replacement TDMs, otherwise known as RMP/TDMs, for all youth entering or exiting a residential care level 6-14 placement.

SFC: DMH currently has 146 staff co-located in 20 DCFS Regional Offices, providing Specialized Foster Care services and an additional 10 positions that are presently vacant will be used for this purpose. An additional 29 positions will be filled in the beginning of FY 2009-10 to support co-located operations.

Mental Health Service Delivery

The County is preparing an expansion of the existing Wraparound program by 2,800 additional slots, as approved by your Board on October 14, 2008, to be accomplished over the course of the next five years, using a two-tiered model. Tier One represents the current Wraparound Program, while Tier Two, with somewhat more flexible referral requirements, is funded with a case rate, an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) allotment, and Mental Health Services Act (MHSA) Full Service Partnership funds.

The timeline for the Tier Two rollout began in May 2009 with the provision of 25 slots per month. An additional 50 Tier Two slots per month will be available beginning in July 2009, at which time the rollout formula will include a total of 75 slots per month.

DMH is currently in the process of amending the contracts of existing Wraparound providers to enhance their EPSDT allocations for Tier One Wraparound services and to provide Tier Two Wraparound services, while the DCFS Wraparound contracts have already been extended.

Another intensive mental health service program, originally discussed in the Corrective Action Plan, where planned rollout of services has been slower than expected, is the County's Treatment Foster Care (TFC) program. Pursuant to the Findings of Fact and Conclusions of Law ordered by Judge Howard Matz of the Federal District Court, the County was directed to develop 300 Treatment Foster Care beds by January 2008. Presently, the County has contracted for 152 beds, but as of June 11, 2009, only 31 Treatment Foster Care homes have been certified and currently only 20 children are placed in these homes.

DCFS has issued a Request for Interest (RFI) to Foster Family Agencies with current mental health contracts to determine their interest in providing Treatment Foster Care and as a result of this process, expects to increase the number of Treatment Foster Care providers and the total number of available beds.

DMH and DCFS have discussed partnering with UCLA on a MacArthur Foundation funded project, pending Board approval, that will provide training for providers in evidence-based mental health practices, ongoing supervision of trained clinicians, the tracking of service provision and client outcomes, and a research-based comparison of outcomes for children receiving the evidence-based services and children who receive more traditional services. This three-year program will provide valuable insight into potentially significant practice changes that can improve the quality of mental health services delivered to children across the county.

Funding of Services/Legislative Activities

The Departments are closely monitoring expenditures this fiscal year and anticipate one-time savings for FY 2008-09 of approximately $15 million. We recommend transferring these funds into Provisional Financial Uses (PFU) to fund a list of priority uses identified for the savings in FY 2009-10 and subsequent years to help offset program costs. The priority uses for the funds consist primarily of Plaintiff/Panel fees, payment for consulting and data matching, evaluation services, Hub capacity expansion, and training on Trauma-Focused Cognitive Behavioral Therapy. A formal request to transfer the FY 2008-09 close-out savings into PFU will be submitted during the supplemental budget process.

DMH, County Counsel and the CEO have been working very closely together to maximize revenue reimbursement to the County and recently drafted a letter to Rick Saletta, the Special Master in the State portion of the Katie A. case. The letter is a follow-up to the County's Declaration submitted, at the request of the Court, and provides the County's recommended clarifications to State DMH Letter No. 08-07 issued in October 2008 regarding Medi-Cal billing for specialty mental health services, such as Wraparound, provided to children in foster care. The letter to Mr. Saletta provides detailed analyses of where the State has too narrowly defined reimbursable Medi-Cal activities and further recommends that the State formally adopt the California

Institute of Mental Health (CIMH) EPSDT Chart Documentation Manual as the official authority on acceptable standards for documenting EPSDT services. Olivia Celis, DMH Deputy Director, expects to submit the letter to the Special Master in the next two weeks for discussion at the next meeting with the Special Master, State, and Plaintiffs' attorneys. The letter will be submitted to your Board from County Counsel under separate cover as confidential information.

At the invitation of the Special Master, Ms. Celis has recently been representing Los Angeles County in a series of weekly facilitated discussions that include the Plaintiffs and Defendants in the State Katie A. case. The meetings will continue over the next ten weeks with the goal of reaching agreement on mutual interests by the parties which would ultimately serve as the basis for a roadmap to the settlement of the State case. Key to the discussion is the reimbursement of the nine components of Wraparound that the plaintiffs' attorneys advocate should be Medi-Cal reimbursable service activities by the State, once the Medi-Cal criteria have been met. Ms. Celis is a key player in these negotiations and has been sharing her perspectives and experiences of managing contracted agencies providing these mental health services, particularly the struggles interpreting the vague guidelines from the State to determine reimbursable services and how this impacts overall service delivery. It is the hope that Ms. Celis' participation in the negotiations will help to further this dialogue and will eventually result in some fiscal relief to counties, in the form of clear guidelines issued by State DMH regarding Medi-Cal reimbursement for the nine components of Wraparound service activities.

There is another related effort underway to maximize revenue reimbursement to the County, which is the pursuit of higher reimbursement rates within the Medi-Cal Schedule of Maximum Allowances (SMA) to cover the higher administrative costs of providing Wraparound related services. The State has been contacted to determine whether a Medi-Cal State Plan Amendment is required to issue a higher reimbursement rate structure. Should the State decline to consider such a request, a legislative approach would be required to set the rate by statute, which would be much more difficult to achieve. That said, the County recently learned of a Civil Action in the State of Massachusetts in which that State was ordered to make a number of improvements in relation to the provision of Medicaid EPSDT services, most notably, to provide ESPDT services within a Wraparound-like continuum of care to children with serious emotional disturbance. We are informed that these improvements are being made with support from the Federal Government and we will be following up to see if an opportunity exists to incorporate lessons learned there about maximizing federal funding for Wraparound services.

Training

DMH and DCFS have worked closely together to develop and implement a number of necessary training components relating to the Strategic Plan, including:

- The development of training materials to support the rollout of the CSAT, including a variety of new policies and practice guidelines associated with mental health screening, obtaining mental health consent and authorization to release information, and the referral of positively screened cases to DMH co-located staff.
- During this time period, DCFS and DMH staff in the Regional Offices in SPAs 6 and 7 were provided training in these Strategic Plan elements and this training will next be provided to the DCFS and DMH staff in SPA 1 starting in July.
- Wraparound training was provided for DCFS Supervising Children's Social Workers to promote the identification and referral of children appropriate for this service.
- MAT training was provided for new MAT providers in SPAs 2, 4, and 8.
- DMH provided training related to AB 3632 for DCFS staff.
- Training in best practices was provided to all of the Wraparound agencies to promote service quality and fidelity to the Wraparound model.

Progress continues to be made on the development of a Core Practice Model, infused with shared practice principles for child welfare and mental health staff associated with the identification of children's needs and strengths, teaming across traditional role boundaries to support the provision of services to meet the needs of children and families, and a coaching/mentoring model to support practice improvement consistent with the elements of the Qualitative Service Review (QSR).

Caseload Reduction

The Strategic Plan outlines a number of initiatives, one in particular lead by DCFS, to support the Department's strong interest in reducing the caseloads of Children's Social Workers (CSWs). We are pleased to report that the progress described in our earlier quarterly update toward achieving the goals outlined in the Strategic Plan continues. Additional reductions have been made in both the screen in rate and the immediate response referral rate. The total number of children in Permanent Placement (PP) has been reduced by over 10 percent and as of April 30, 2009, the PP caseload was at 13,199 children. Generic caseloads have been reduced from an average of 26 children per worker to 23 children per worker as of April 2009, while the Emergency Response (ER) caseload has been reduced from an average of 24 children per worker to 21 children per worker.

DCFS has also made significant strides in hiring new CSWs, with 348 new CSWs hired from June 2008 through April 2009, exceeding the goal of 160 new hires described in the Strategic Plan. As of April 2009, the CSW vacancy rate was at only three percent.

Data/Tracking of Indicators

DMH and DCFS continue to work toward hiring staff to support the development of an electronic system for tracking and reporting on data indicators. DMH and DCFS, each have one Information Technology position left to fill. In the meantime, as previously mentioned on page 4, DCFS has developed an interim RTS to track the systematic implementation of mental health screenings per SPA and DCFS offices according to the three tracks for screening: newly detained cases; newly opened non-detained cases; and existing open cases. This interim system is part of a larger automated effort to comprehensively store and track, without violating Statewide Automated Child Welfare Information System (SACWIS) regulations, child welfare and mental health service information regarding mental health screenings, referral to DMH for positive screens, and receipt of mental health service. The RTS is in the early design phase and greater functionality and expanded access for DMH clinicians will be sought from the California Department of Social Services in the next few months, and if granted, will culminate in the solicitation for consultant services to enhance the DCFS system and to better integrate the provision of DMH services into one central location.

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the successful adoption by the Board of Supervisors of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators, and a passing score on the QSR measure.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by the Board, Katie A. advisory panel, and plaintiffs' attorneys. The Federal Court has received a copy of the Strategic Plan, but further discussion of the related data exit conditions is needed before Court action. We anticipate provisional exit conditions will be reached within the next few months and we are hopeful Court approval of the Strategic Plan will occur around the same time.

DMH and DCFS, in conjunction with the Katie A. Advisory Panel, County Counsel, CEO and plaintiffs' attorneys have developed a discrete set of data indicators targeting Safety, Permanency, and timelines/percent standards for completing mental health screenings, referring positive screens to mental health services, and tracking receipt of mental health services. Several of the exit indicators are Child and Family Services Review (CFSR) measures that will be tracked as either formal exit criteria or contextual information for monitoring compliance with the Settlement Agreement. The County is currently discussing with the panel and plaintiff's attorneys the DCFS population subset(s) to be tracked, proposing to track some of these exit criteria for a period of six months in order to establish a performance baseline from which to negotiate a final set of exit criteria.

As discussed in the last quarterly update, DCFS has hired a Children's Services Administrator II (CSA) to head a Quality Improvement Section that will have lead responsibility in implementing the QSR process. DMH has just hired a Mental Health Counselor, Registered Nurse, who will serve as the DMH liaison for this effort. With staff now in place, the development of a contract for a tailored QSR instrument, testing of the instrument, recalibrations to the instrument based on the testing, protocol for administering the instrument, training of reviewers, and QSR implementation planning will get underway.

Summary

In the last six months there have been significant strides in the implementation of the Strategic Plan, including:

- Delivering Katie A. Strategic Plan presentations in all DCFS Regional Offices, in addition to DMH contract providers, ACHSA, dependency court judicial officers, and attorney representatives;
- Opening of the Satellite Medical Hub in El Monte;
- Development and provision of CSAT training curriculum on mental health screening, consent, authorization to release protected health information, and service linkage for SPA 7 and 6 offices and Wraparound training countywide;
- Implementation of the CSAT in SPA 7 offices;
- Launching of the RTS on May 1, 2009;
- Implementing the MAT Program in all regional offices except SPA 5;
- Developing procedures and forms for mental health consent and the authorization to release protected health information;
- Extension of DCFS Wraparound contracts;
- Drafting a letter to the State's Special Master clarifying allowable Medi-Cal billing for mental health services provided in a Wraparound continuum; and
- Continued progress in caseload reductions.

The next quarterly report detailing our progress will be provided to your Board on September 30, 2009.

Please let us know if you have any questions regarding the information contained in this report, or your staff may contact Olivia Celis, DMH Deputy Director, at (213)738-2147 or ocelis@dmh.lacounty.gov .

MJS:OC:GL

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

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Reply To: (213) 738-4601
Fax: (213) 386-1297

September 30, 2009

TO: Each Supervisor

FROM: Marvin J. Southard, D.S.W.
Director of Mental Health

Patricia S. Ploehn, L.C.S.W.
Director of Children and Family Services

SUBJECT: KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

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- Enhanced Specialized Foster Care Mental Health Services Plan (2005)
- Findings of Fact and Conclusions of Law Order, 2006, issued by Federal District Court Judge Howard Matz
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The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

- Mental health screening and assessment
- Mental health service delivery
- Funding of services
- Training

- Caseload reduction
- Data/tracking of indicators
- Exit criteria and formal monitoring plan

The Strategic Plan also provides that the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS) would inform your Board of any revisions to the implementation of the Strategic Plan by March 2009, and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan, this report will also describe any significant deviations from the planning described in those documents.

The Departments have been directed to conduct an annual assessment in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement. In the interim, quarterly reports have been submitted on implementation activities in March and June of this year.

This memo will serve as the third update to our progress in implementing the Strategic Plan.

Implementation Support Activities

A number of activities were conducted during this period to support the implementation of the Strategic Plan.

- DCFS Director Trish Ploehn and DMH Director Dr. Marvin Southard issued a joint memorandum regarding the role of the DMH co-located staff in responding to consultation requests from DCFS Children's Social Workers.

- The Katie A. Strategic Plan was formally approved by the Federal District Court in July in fulfillment of one of the County's formal exit conditions.

- DCFS Medical Director Dr. Charles Sophy, DCFS Katie A. Division Chief Adrienne Olson, DMH Deputy Director Olivia Celis, and DMH Child Welfare Division District Chief Greg Lecklitner met with Adoptions, Family Preservation, and Medical Case Management Services to provide an overview of the Plan's basic elements and engage in dialogue regarding implementation issues.

- Chief Executive Office (CEO), DCFS, and DMH continue to participate in a variety of Katie A. related meetings, including monthly Executive Leadership Team meetings, bi-weekly Project Leadership Team meetings, and monthly Katie A. Operations meetings. Departmental managers and Katie A. Panel members are also provided with bi-weekly Katie A Updates.

- Monthly progress reports have been prepared for your Board providing updates on the rollout of the screening, assessment, and treatment elements of the Strategic Plan, including Referral Tracking System (RTS) Summary Data Sheets.

- DCFS continues to develop and maintain the Katie A. Website.

- DMH and DCFS leadership met with the Association of Community Human Service Agencies (ACHSA) to discuss the Katie A. implementation effort related to the Coordinated Services Action Teams, the Wraparound Program and the Multidisciplinary Assessment Teams (MAT) Program.

- Ongoing workgroup meetings are taking place across 18 major activity domains associated with the Strategic Plan and the progress of these workgroups is being documented in individual Project Data Sheets.

- DCFS has now filled 60 of the 61 positions allocated for fiscal year (FY) 2008-2009, and DMH has filled the 3 positions allocated for this same time period. In addition, DCFS is allocated 20 (10 professional and 10 clerical) positions for FY 2009-2010, has posted the vacancies and anticipates filling these positions by November 2009. Three of these positions are now filled pending release. DMH is allocated an additional 39 positions for FY 2009-2010 and is currently in the process of hiring these staff.

- Department representatives have participated in a two-day meeting with the Katie A. Advisory Panel, discussing Treatment Foster Care, budgetary issues, the Qualitative Service Review (QSR), the rollout of the Coordinated Service Action Teams (CSAT), Wraparound, exit indicators, and the Core Practice Model.

- DMH has participated in two grant applications to support Katie A. related initiatives including a one day conference on best mental health practices for children in the child welfare system and a policy and advocacy project for dependent teen parents and their children.

- CEO, DMH, and DCFS are also engaged in discussions with First 5 LA regarding possible financial support for a Katie A. related project.

Additional implementation activities associated with the Strategic Plan, organized in accord with the basic elements of the Plan, are described below.

Mental Health Screening and Assessment

The Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health services. Nine Project Teams comprise the Screening and Assessment component of the Plan as follows: 1) Medical Hubs; 2) Coordinated Services Action Team (CSAT); 3)

Multidisciplinary Assessment Team (MAT); 4) Referral Tracking System (RTS); 5) Consent/Release of Information; 6) Benefits Establishment; 7) D-rate; 8) Team Decision-Making (TDM) and Resource Management Process (RMP); and 9) Specialized Foster Care (SFC). Significant progress continues to be made by each of these project teams.

Medical Hubs: As of May 2009, 73 percent of newly detained children received an Initial Medical Examination at a Hub. A comprehensive plan has been developed to ensure 100 percent of the newly detained population is served by the Medical Hubs. The LAC+USC East San Gabriel Valley Satellite Hub began serving DCFS children placed in the eastern part of Los Angeles area on June 15, 2009. Opening of this satellite Hub is significantly reducing travel time for many caregivers. The revised DCFS Medical Hub Policy was released on July 23, 2009, with a small update on September 3, 2009, which specifies mandatory timeframes for submission of the Medical Hub Referral Form. In accordance with the rollout of the CSAT and RTS in each office, Medical Hub referrals will be tracked to ensure compliance with the mandate. Additionally, the web-based medical records system, E-mHub, will allow the Medical Hub referrals to be submitted from DCFS to the Medical Hubs electronically as well as health and mental health information.

With the release of the revised DCFS Medical Hub policy, CSAT implementation in SPAs 1, 6 and 7, and recent child deaths, there has been an increase in the number of children referred to the Hubs. The monthly average in FY 2008-2009 was 1,450 children and the average number of children served by the Hubs in the first two months of FY 2009-2010 is 1,750. The Departments have conducted an analysis of their needs and have developed a proposal to increase medical hub capacity to serve newly detained children and have been refining a subsequent proposal to ensure that the needs of prioritized populations including referrals under investigation and non-detained children will be met, in addition to the population of children currently served by the Hubs.

CSAT: On May 1, 2009, CSAT was implemented in Service Planning Area (SPA) 7 (the Belvedere and Santa Fe Springs offices). On August 1, 2009, CSAT was implemented in SPA 6 (the Compton, Wateridge and Vermont Corridor offices) and a CSAT "dry run" was underway in August 2009 for SPA 1 (Lancaster and Palmdale offices), with the official implementation of CSAT occurring on September 1, 2009. By September 2009, all Phase I offices will have implemented CSAT and will begin hiring 20 additional staff to support the CSAT process in the Phase II offices scheduled to begin training in late October 2009, with CSAT implementation in January 2010 for SPA 3 (Glendora, Pomona, Pasadena and El Monte offices).

It is important to note that the 20 positions, originally budgeted to be filled in July 2009, will now all be filled by December 2009, rather than the last quarter's plan to stagger the staffing of these positions over the fiscal year three months prior to CSAT implementation. It was determined that hiring the CSAT Service Linkage Specialists

(SLSs) and Screening Clerks earlier was needed to not only support CSAT in the current implemented offices, but also to provide on the job training for new CSAT staff.

DCFS expects to have full implementation of CSAT in all offices by December 31, 2010.

MAT: Experienced MAT Operations staff in SPAs 3 & 6 are referring 85 to 95 percent of all the eligible MAT cases for a MAT assessment, whereas less experienced SPAs are at different formative stages. In SPAs 2 and 8, 70 to 80 percent of all eligible cases are being referred to MAT. SPAs 4 and 7 are referring between 60 to 70 percent of all eligible cases until more capacity is developed. SPA 1 has referred only 20 to 30 percent of their eligible cases due to low MAT provider capacity to accept these referrals. Finally, SPA 5 is scheduled to begin accepting MAT referrals on October 1, 2009. This will complete countywide MAT implementation.

During FY 2008-2009 a total of 1,542 MAT Assessments were completed compared to only 433 during the FY 2007-2008. This is due to the expanding MAT roll-out. It is expected that more than 2,000 MAT assessments will be completed by the end of the FY 2009–2010, as MAT capacity expands with existing providers. Currently there are 50 trained community-based mental health agencies trained to provide MAT assessments countywide.

RTS: The Referral Tracking System became operational on May 1, 2009 in the SPA 7 offices, expanded to SPA 6 offices on July 1, 2009 and SPA 1 offices on September 1, 2009. DCFS and DMH continue to make refinements to the system as the benefit of reporting on additional data is identified and business rules developed. Beginning May 30, 2009, detailed summary data reports are produced and submitted to your Board on a monthly basis. As of September 14, 2009, 3,186 children have been screened for mental health needs since May 1, 2009 and 96 percent of those children found to be in need of mental health services received such services during this same time period.

In September DMH will complete the development of a DMH Referral Tracking System that will provide automated support for the collection of data related to the preparation of the monthly reports provided to your Board.

Consent/Release of Information: DCFS and DMH, in concert with their respective County Counsels, have developed procedures and forms to provide for the consent for mental health services for referred children as well as the authorization to release protected health information for purposes of the child's care and coordination of services. Meetings with Children's Law Center, the Los Angeles Dependency Lawyers, judicial officers, county counsel, and DMH and DCFS management continue to take place in an effort to finalize language and protocols related to the securing of consent and the authorization to release information.

Benefits Establishment: In August 2009, the CSAT team of MAT Coordinators, Service Linkage Specialists and Screening Clerks were given access to the MEDSLITE benefits establishment system. MEDSLITE is a condensed version of the Medical Eligibility

Determination System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. The timely determination and accuracy of a child's benefits assists the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

D-Rate: In addition to the D-rate program's continued work to review and ensure mental health services for at least 90 percent of D-rate children, the duties of the DCFS D-rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning and service coordination for other high-need children.

TDM/RMP: Eight TDM facilitators were hired in the last quarter, now totaling 84 DCFS facilitators available to coordinate TDMs and RMPs. In December 2008, DCFS mandated replacement TDMs, otherwise known as RMPs, for all youth entering or exiting a Residential Care Level (RCL) 6-14 placement. Each regional office developed and implemented a "firewall" to ensure all youth entering, or exiting a RCL had a RMP. The initial results from the RMP analysis show that the process is having a positive impact on the timely connection to services and the number of subsequent replacements.

SFC: The DMH Service Area Specialized Foster Care Managers meet on a twice-monthly basis with the DMH Child Welfare Division Managers to discuss implementation issues related to the various Katie A. related initiatives. DMH now has a total of 313 items dedicated to support the work of Katie A., including 64 countywide administration items and 249 Service Area items. The Child Welfare Division continues to provide countywide support for the implementation of the various Katie A. initiatives, including Wraparound, MAT, the SFC staff that are co-located in the DCFS Regional Offices, data management, training, and the development of practice guidelines.

Mental Health Service Delivery

The County is preparing an expansion of the existing Wraparound program by 2,800 additional slots, to be accomplished over the course of the next five years, using a two-tiered model. Tier I represents the current Wraparound Program, while Tier II, with somewhat more flexible referral requirements, is funded with a case rate, an Early Periodic Screening, Diagnosis, & Treatment (EPSDT) allotment, and Mental Health Services Act (MHSA) Full Service Partnership funds

On May 1, 2009, the County implemented Tier II, an expansion of the current Wraparound program. Tier I serves youth currently in, or at imminent risk of RCL 10 or above placement, while Tier II serves only DCFS youth with EPSDT and who are not eligible for Tier I.

Tier II initial rollout began with the provision of 25 slots per month. An additional 50 Tier II slots per month were available on July 2009. As of September 4, 2009 there were approximately 168 youth in Tier II and approximately 1,084 in Tier I.

Another intensive mental health service program, originally discussed in the Katie A. Corrective Action Plan (CAP), where planned rollout of services has been slower than expected, is the County's Treatment Foster Care (TFC) program. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge Howard Matz, the County was directed to develop 300 treatment foster care beds by January 2008. Presently, the County has contracted for 152 beds, but as of September 18, 2009 only 38 treatment foster care homes have been certified and currently only 26 children are placed in these homes.

In a response to a Request for Interest (RFI) sent to Foster Family Agencies (FFA) with current mental health contracts, the number of agencies submitting program statements to provide Intensive Treatment Foster Care FFA (ITFC-FFA) or an Intensive Treatment Foster Care - Multidimensional Treatment Foster Care FFA (ITFC-MTFC FFA) increased from 5 to 16 (12 for ITFC-FFAs and 4 for ITFC-MTFC FFAs). Currently, Community Care Licensing (CCL) in Sacramento is reviewing these 16 program statements. DCFS will be requesting the Board of Supervisors to authorize the execution of the 16 contracts. Final CCL approval and Board of Supervisor authorization would put the TFC program in a good position to meet the expected goal of 300 contracted beds by December 2012.

Other progress includes the hiring of a Children's Services Administrator II (CSA II) as TFC program manager and the development of a TFC CAP. The plan identifies the critical barriers that currently impede the effectiveness of the TFC program and outlines corresponding strategies and resources needed to overcome these barriers. The addition of the program manager and the TFC CAP will strengthen the TFC program and improve the likelihood of meeting the expected goals.

During the September meeting with the Katie A. Panel, DMH presented a plan for a major transformation of the County's children's mental health system, consistent with the obligations required by the Katie A. Settlement Agreement. DMH will be seeking to implement a Core Practice Model for service delivery that will provide for a flexible array of services, both formal and informal, for children and families based upon a needs and strengths-based approach and a child and family team service planning process.

In September DMH is also beginning a Client Satisfaction Survey process for children and families that have received services pursuant to their referral to mental health as a result of the CSAT process. The results of this survey will be shared with your Board on a regular basis as part of the monthly report.

Funding of Services/Legislative Activities

Recently the Departments met with Budget and Children's Board Deputies and were directed to transfer approximately $16 million in Katie A. FY 2008-09 savings into a Provisional Financial Uses (PFU). The request to transfer the savings into a PFU will

be incorporated into the supplemental budget process and discussed on September 22, 2009 at the Board Meeting to consider supplemental budget recommendations.

DMH, County Counsel and the CEO have been working very closely together and submitted a letter earlier in the summer to the Special Master, Rick Saletta, in the State portion of the Katie A. case. The letter provides the County's suggested clarification to a State DMH All County Letter issued in October 2008 regarding Medi-Cal billing for specialty mental health services, such as Wraparound, provided to children in foster care. The letter to Mr. Saletta provides detailed analyses of where the State has narrowly defined reimbursable Medi-Cal activities and further recommends that the State formally adopt the EPSDT Chart Documentation Manual as the official authority on acceptable standards for documenting EPSDT services.

DMH continues to participate weekly in negotiations, led by a court-appointed Special Master, with the State and Plaintiff attorneys regarding the State portion of the Katie A. lawsuit. It is hoped that resolution of the State case will result in improved claiming opportunities for Katie A. related mental health services, particularly through Wraparound related service activities.

There is another related effort underway to maximize revenue reimbursement to the County, which is the pursuit of higher reimbursement rates within the Medi-Cal Schedule of Maximum Allowances (SMA) to cover the higher administrative costs of providing Wraparound related services. Such a process would likely have to be embedded in the State Plan Amendment (SPA) process for MediCal reimbursable mental health services. The County has contacted the State for additional information and is awaiting word back from the State. The County has also made repeated contacts to program officials in the State of Massachusetts to learn more about the improvements that State was ordered to make by a Federal Court in relation to the provision of Medicaid EPSDT services, most notably, to provide EPSDT services within a Wraparound-like continuum of care to children with serious emotional disturbance.

The County has enlisted a three-pronged approach to mitigate ongoing Katie A. service delivery costs through enhanced revenue reimbursement of EPSDT claiming by: 1) participating in the discussions with the Special Master in the State portion of the Katie A. case to express the County's disagreement with the State's narrow interpretation of Medi-Cal claiming guidelines; 2) conversations with the State to augment the SMA; and 3) to identify any lessons learned in the Massachusetts case in maximizing EPSDT revenue for mental health services delivered in a Wraparound continuum of care. We will continue to keep the Board apprised of our efforts to offset ongoing service delivery costs.

Training

DMH and DCFS have continued implementation of the necessary training components relating to the Strategic Plan, including:

- Completion of Regional Office Overview Trainings/Visits for DMH and DCFS staff on Katie A. Plan components, requirements and training plans.

- Continued CSAT training to support the rollout of the CSAT including training on new policies and practice guidelines associated with mental health screening, the obtaining of mental health consent and authorization to release information, and the referral of screened cases to the DMH co-located staff. CSAT training has been completed for SPAs 1, 6 & 7, for the DCFS Command Post Supervising Children's Social Workers (SCSWs), DMH Family Preservation, D-Rate staff, DCFS Specialized Programs, and the Martin Luther King (MLK) Hub.

- Wraparound training was provided for DCFS SCSWs to promote the identification and referral of children appropriate for this service in accordance with Katie A. Plan components and commitments. Follow up training on Wraparound for CSWs is to be piloted in October 2009.

- Continued provision of training to support targeted strategies for outcome achievement (safety, permanence and well-being) to facilitate safe caseload reduction including TDM training, Emergency Response Policy/Practice, and Intentional Visitation.

- MAT training has now been provided for line staff and MAT providers in all SPAs.

- DMH provided training related to AB3632 for DCFS staff.

- DMH and DCFS provided training for co-located DMH staff, new Resource Utilization and Management (RUM) staff, and Wraparound providers regarding the use of the Child Adolescent Needs and Strengths (CANS) Tool.

- Continued training and technical assistance was provided to all of the Wraparound agencies to promote service quality and fidelity to the Wraparound model.

DMH and DCFS are jointly leading development and finalization of a (shared) Core Practice Model (CPM), infused with practice principles for child welfare and mental health and informed by community partner and stakeholder input. The CPM will serve to align the two Departments and the continuum of providers in the identification of children's needs and strengths, in teaming across traditional role boundaries to support the provision of services to meet the needs of children and families, and in implementing coaching/mentoring models to support practice improvement consistent with the elements of the QSR.

Caseload Reduction

The Strategic Plan outlines a number of initiatives to be undertaken by DCFS in support of the Department's need to reduce the total departmental foster care as well as the caseload sizes of CSWs in order to accomplish the Strategic Plan goals. We are pleased to note that the progress reported in our first quarterly update continues.

The Department's total out-of-home caseload has been reduced from 15,748 as of May 2009 to 15,563 as of July 2009. Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanence and well-being (including early mental health intervention) for the children in our care.

As for individual CSW caseload sizes the number of children in generic caseloads have been reduced from an average of 26 children per worker to 22.72 children per social worker as of July 2009, while the Emergency Response (ER) caseload has been reduced from an average of 24 children per social worker to an annualized average of 20.26 children per worker (date to date). The decrease in caseload sizes are attributed to a number of factors, but one key is that 434 new CSWs were hired from June 2008 through July 2009, exceeding the goal of 160 new hires described in the Strategic Plan. In addition, as of September 2009, the CSW vacancy rate is only at 2 percent.

CSWs and regional management have been consistently reporting that the reduced caseload sizes are noticeable and much appreciated. They state that they are increasingly able to do more thorough casework and give the cases the attention they need to broker necessary mental health services for the children on their caseloads.

Data/Tracking of Indicators

DMH and DCFS continue to work toward hiring the staff to support the development of an electronic system for tracking and reporting of data indicators. DMH has now hired the three DMH Chief Information Office Bureau (CIOB) positions approved through the CAP. DCFS has selected staff for four of the five Information Technology (IT) positions requested in the Strategic Plan.

DCFS has developed an interim RTS to track the systematic implementation of mental health screenings per SPA and DCFS offices according to the three tracks for screening: newly detained cases, newly-opened non-detained cases, and existing cases. This interim system is part of a larger automated effort to comprehensively store and track, without violating State Automated Child Welfare Information System (SACWIS) regulations, child welfare and mental health service information regarding mental health screenings, referral to DMH for positive screens, and receipt of mental health service. The RTS is in the early design phase and greater functionality and expanded access for DMH clinicians will be sought over the next several months culminating in the development of a data tracking solution that will provide an integration of DCFS and DMH data sources to track all DCFS referrals for mental health services

and provide information regarding service delivery. The DMH CIOB is currently developing the project plan for this solution and has completed the interim solution that will be used to automate the collection of information to be used for the Katie A. monthly reports to your Board.

In the interim, DMH and DCFS continue to perform monthly client matches with the assistance of the Internal Services Department (ISD) and this data is used to update the DMH Cognos Cube. A recent data extraction from the Cognos Cube demonstrated an impressive increase in the penetration rate of mental health services for DCFS-involved children, from 34 percent in FY 2002-2003 to 56 percent in FY 2008-2009.

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the successful adoption by the Federal District Court of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators and a passing score on the QSR measure.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by the Board, Katie A. Advisory Panel, and Plaintiffs' attorneys, and, as previously noted, the Strategic Plan was approved by the Federal District Court on July 22, 2009. This notes the first time since the inception of the lawsuit that a County developed Plan for Katie A. has been approved by the Court, which is a significant achievement in itself for the County and identifies a practical timeline with objective criteria for exiting the lawsuit.

DMH, DCFS, and CEO in conjunction with the Katie A. Advisory Panel, County Counsel, and plaintiffs' attorneys, continue to work on finalizing a discrete set of data that will be tracked as either formal exit criteria or contextual information as one of three prongs, described below in "Exit Criteria" for monitoring compliance with the Settlement Agreement. A detailed work plan is being developed to finalize Safety and Permanency exit indicators by the end of this calendar year. The County is proposing to track some of the mental health screening, assessment, and service delivery exit criteria for a period of six months in order to establish a performance baseline from which to negotiate a final set of exit criteria.

The QSR process is planned to take place in three phases. Phase One calls for the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan. These activities are expected to be completed between July 2009 and July 2010.

Phase Two, to be completed between September 2010 and December 2012, commences the administration of the QSR across the 18 DCFS Regional Offices; while Phase Three, to be completed by December 2013, consists of any follow up reviews that might be necessary to achieve passing scores.

DCFS has hired a CSA II to head a new Quality Improvement (QI) Section that will have lead responsibility in implementation of the QSR process. DMH has now hired a Mental Health Counselor R.N. who will serve as the liaison from DMH in this effort. DCFS and DMH staff has planned a visit to Utah in November to participate in their QSR process as a preview of the activities that will need to take place in Los Angeles County. Now that staff is in place, the QSR protocol will be detailed in the coming months including the proposed sample size, percent standard for achieving a passing score, and criteria for exiting the review process.

During the time since the last quarterly report, the focus has been on the development of a Statement of Work and the procurement of consultation services for our QSR. On July 17, 2009 DCFS informed the Board that it intended to commence negotiations for a sole source contract with Human Systems and Outcomes, Inc. (HSO). These negotiations began on July 31, 2009. HSO is a for-profit management consulting and performance measurement organization that holds the copyright on the QSR Tool. It is anticipated that DCFS will be seeking approval from the Board of the QSR contract, by December 9, 2009, with a projected execution date of January 12, 2010.

SUMMARY

The implementation of the Katie A. Strategic Plan is being fully executed by the Departments and progress has been made toward achievement of the Settlement Agreement objectives. The Strategic Plan has been organized into eighteen project teams, each having sponsors, managers, team members and Project Data Sheets that are updated quarterly to summarize the objectives, outcomes, deliverables, resources, dependencies, risks and benefits. The Departments' steadfast oversight and collaboration, facilitated through the Katie A. Executive Leadership Team and the Project Leadership Team, are evident and rapidly moving the County toward resolution of its obligation.

During the last three months, the County has continued to demonstrate significant progress toward meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Among the most significant accomplishments are:

- Approval of the Katie A. Strategic Plan by the Federal District Court, fulfilling one of the County's three major exit standards;

- Expansion of the County's capacity to serve newly detained children via the opening of a Hub satellite in the East San Gabriel Valley;

- Expansion of the County's capacity to provide Wraparound services through the implementation of Tier Two Wraparound services;

- Increased capacity to perform MAT assessments with the completion of the MAT contracting process and training of 50 MAT providers;

- The mental health screening by DCFS of over 3,000 DCFS children and related referrals for mental health services;

- Further refinements in the implementation of an automated referral tracking system to document the mental health screening, assessment, and treatment of children served by DCFS;

- Ongoing large-scale training efforts related to the Strategic Plan, including Wraparound, MAT, and CSAT;

- Continued reductions in the caseloads of DCFS CSWs;

- Demonstration of a significant increase in the penetration rate of mental health services for DCFS involved children;

- Staffing in place for both DCFS and DMH to implement the QSR, another of the Katie A. exit conditions;

- Continued participation in negotiations between plaintiff attorneys and State representatives in the State portion of the Katie A. lawsuit.

As a result of these ongoing efforts, the County continues to enjoy a positive working relationship with the Katie A. Advisory Panel and the Federal District Court overseeing the Settlement Agreement.

This is the last quarterly report for 2009 that will be reported to your Board. In January 2010, an evaluation of the first year's implementation activities will be provided and the quarterly reporting schedule for 2010 will resume with quarterly reports provided to your Board in March, June, September and December.

Please let us know if you have any questions regarding the information contained in this report, or your staff may contact Olivia Celis-Karim, DMH Deputy Director, at (213) 738-2147 or ocelis@dmh.lacounty.gov .

MJS:PSP:OC:GL:nr

c: Chief Executive Officer
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WILLIAM T FUJIOKA
Chief Executive Officer

February 1, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

REPORT ON FIRST YEAR IMPLEMENTATION EVALUATION OF THE KATIE A. STRATEGIC PLAN ADOPTED BY THE BOARD OF SUPERVISORS ON OCTOBER 14, 2008

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period.

An implementation evaluation of the Enhanced Specialized Foster Care Plan (Plan) - the first Katie A. Plan developed to address the requirements of the Settlement Agreement - was conducted by Health Management Associates (HMA) in June 2007. The HMA critique cited several key issues impeding successful implementation, including:

- The lack of a clearly articulated vision of the desired "system of care" for foster children with mental health needs, accompanied by policies and procedures to guide implementation;

- Lack of training specific to the system of care; and

- Lack of data to demonstrate that critical elements of the Plan have been achieved, including completion of mental health screening for all detained children, completion of mental health assessments for all children with a positive mental health screening, and linkage and receipt of necessary mental health services for children with an assessed need for services.

The Strategic Plan is focused on addressing these barriers to successful implementation through the creation of enhanced staffing structures/teaming practices, joint Departments of Children and Family Services (DCFS)/Mental Health (DMH) policy directives, and joint training sessions to disseminate the primary components of the Strategic Plan and expectations for implementation. That said, improvements to the screening, referral, assessment, and linkage to children's mental health services continue to evolve and be refined over time as we learn to enhance operational effectiveness.

The Chief Executive Office (CEO), DCFS, and DMH committed to conduct an assessment in January 2010 to evaluate the first year Strategic Plan implementation rollout, Plan financing, and status of efforts to maximize revenue reimbursement. A consultant was contracted to conduct a series of focus groups and interviews through November and December 2009 in Service Planning Areas (SPAs) 1, 6, and 7 to determine the effectiveness of the Katie A. Strategic Plan and related Coordinated Services Action Team (CSAT) rollout and implementation in the Phase I offices (Attachment I).

A total of 27 focus groups at seven DCFS offices were conducted across the three SPAs, which included four participant groups: 1) Children's Social Workers (CSWs); 2) Supervising Children's Social Workers (SCSWs); 3) DMH co-located Specialized Foster Care staff/supervisors; and 4) DCFS CSAT staff, inclusive of the CSAT lead per area office, Service Linkage Specialist (SLS), Multidisciplinary Assessment Team (MAT) Coordinators, Wraparound Liaisons, D-Rate Evaluators, Public Health Nurses (PHNs), educational liaisons, Youth Development Specialists, Permanency Partners Program (P3) staff, Adoption Safe Families Act staff, Linkages co-located staff, Resource Utilization Management (RUM)/Resource Utilization Management Process (RMP) staff, and Team Decision Making (TDM) Facilitators. The data collection process also included 23 individual interviews with DCFS Regional Administrators/Assistant Regional Administrators and DMH District Chiefs/Program Heads.

The focus groups examined the following topical areas:

- Mental Health Screenings: To what extent and in what manner were children in child welfare being screened for mental health needs?

- Referrals to Assessments for Children with Positive Mental Health Screenings: To what extent and in what manner are children in foster care with a positive mental health screening being referred to an assessment?

- Assessments for Children with Positive Mental Health Screenings and Linkage to Mental Health Services: To what extent and in what manner are children with a positive mental health screening being assessed and linked to mental health services?

- Mental Health Service Provision: To what extent and in what manner are mental health services being provided to children with mental health needs?

Executive Summary: Highlights from Implementation Evaluation

The evaluation project found that the screening and referral processes were the components most successfully implemented in this initial phase. By contrast, the assessment and service linkage processes encountered the greatest challenges. Service provision also faced numerous challenges, but the implementation of this component was too recent in two of the three SPAs to gauge its key strengths and challenges.

The following sums up the specific strengths and challenges of implementing the four components:

1. Mental Health Screening Process

   Strengths: The process put in place to screen for the mental health needs of children in the child welfare system seems robust across the seven sites. The implementation included seven elements that comprise a "system"': (a) an easy-to-use screening tool for mental health needs; (b) practical training on how to administer the screening tool; (c) ongoing formal and informal support on how to fill out the screening tool; (d) explicit protocols and roles specifying who is responsible for filling out the screening tool; (e) multiple checkpoints to ensure that all children have a completed screening tool on file; (f) a data-tracking system that alerts staff members to the status of the child; and (g) cross-system ownership over the early identification of mental health needs.

   Key challenges: Ensuring that all children with existing cases are screened for mental health needs, and administering the mental health screening tool consistently across different, complex, and time-limited situations, including the medical Hubs.

2. Referrals to Assessments

Strengths: The process of referring children with positive mental health screenings to assessments also appears to be strong and functioning as a 'system'. Offices have formal procedures for referring cases, clear roles and responsibilities, a checklist of what constitutes a completed referral packet, and a data-tracking system to keep the case moving toward an assessment. The coordinators of MAT and the SLS play instrumental roles in ensuring that the 'packets' required to conduct an assessment are prepared quickly and fully: they participate in TDM sessions with relevant stakeholders early in the process to focus on the newly detained, non-detained, or existing case; and they are also authorized to access the MedsLite system to accelerate the determination of Medi-Cal eligibility for children.

Key challenges: Obtaining the necessary consent for services in a timely fashion, and determining, obtaining and maintaining benefits for certain children in the child welfare system that are eligible for Medi-Cal.

3. Assessment and Linkage Activities

Strengths: The CSAT is viewed as a structure that has brought greater order, efficiency, and accountability to assessment and linkage services for newly detained cases (Track 1) and non-detained and existing cases (Tracks 2 and 3, respectively). CSWs underscored that CSAT brings together staff with special skills, knowledge, resources and networks to ensure that children who are newly detained, non-detained or with existing cases are appropriately and efficiently assessed and linked to services.

However, in contrast to screening and referral processes, staff members reported encountering a greater number of implementation challenges with assessment and linkage activities.

Key challenges: Varied by track and SPA:

- Track 1 (Newly Detained Cases): Availability of Assessment Slots and Assessment Capacity Issues: In some SPAs, as the providers began to ramp up their staffing to perform MAT assessments, the number of newly detained children needing assessments exceeded the amount of MAT spaces available for assessments; and in some instances, MAT providers responsible for coordinating assessments and linkage lacked the linguistic, cultural, or other capacities to conduct assessments. These issues were particularly present in SPA 1.

- Track 1 (Newly Detained Cases): Difficult Deadlines, Expectations, and Additional Costs: Staff involved with Track 1 cases reported conflicting or unrealistic deadlines for completing the assessments, chronic delays with reports essential to completing the assessments (especially medical Hub reports), inconsistent expectations for completing an assessment (especially the Summary Findings Report), and the inability to cover the full costs of assessment and linkage services.

- Track 2 and 3 (Non-Detained and Existing Cases): Distancing, Roles, and Partnerships: Case-carrying CSWs involved with non-detained and existing cases reported feeling increasingly distanced from the case and the mental health service providers as the case moved through the assessment and linkage process facilitated by the SLS and DMH Co-located staff; Co-located staff stressed feeling that their roles in linking children to services have expanded beyond their skill sets; and Co-located staff also indicated that the collaboration with DCFS has not been entirely conducted as an equal partnership, thus impacting DMH Co-located staff morale.

4. Mental Health Service Provision[1]

Strengths: All offices expressed confidence that Wraparound services provided mental health services in accordance with the practice principles specified in the Strategic Plan. CSWs and Intensive Social Workers (ISWs) reported that they regularly check in with Wraparound service providers regarding case files.

Key challenges: Centered on non-Wraparound services.

- First, CSWs revealed a lack of clarity concerning their role(s) in Child/Family Teams specified in the Strategic Plan. (It should be noted that the Core Practice Model training curriculum, which will articulate teaming and family engagement expectations and practices for DCFS, DMH, and contracted mental health providers, is still being developed and has not been implemented yet.)

[1]Line staff reported having less experience with mental health service provision. In large part, this is due to the fact that two of the three SPAs had only just begun implementing the Strategic Plan. Moreover, mental health providers were not part of the focus groups or interviews. Most information about mental health service provision came from CSWs and DMH Co-located staff focus groups, supplemented by a special meeting of the Children's Mental Health Providers Network held on December 2, 2009.

- Second, CSWs cited the lack of strong mechanisms for cross-agency collaboration that integrate them into service provision teaming structures. CSWs indicated that most of the communication between them and mental health providers tends to revolve around court-mandated reports or file updates and that these reports do not typically contain qualitative information that would help determine case outcomes. CSWs cited confidentiality regulations as a barrier to accessing more in-depth qualitative information beyond what is court-mandated.

- Third, mental health service providers felt confident in being able to implement services using the practice principles stipulated in the Strategic Plan (for example, Core Practice Model, Trauma Informed Practices, and Intensive Home-Based Services). However, they stressed three structural constraints that affect their capacity to implement mental health services in accordance with the practice principles: the inability to bill fully for the array of services; the costs of training staff members in the practice principles (especially if universities are not training new professionals in these practice skills); and a perception that department managers lack clear buy-in and a set of expectations about the practice principles.

RECOMMENDATIONS

The recommendations, presented herein, respond to the implementation challenges identified by staff with the screening, referral, assessment and linkage, and service provision activities. These recommendations are presented in the form of goals, rather than specific strategies. The development of specific strategies to address these recommendations, as well as the planning structures needed to arrive at those solutions (for example, committees, timelines, etc.), is outside the scope of this evaluation project and will require bringing together people with the relevant knowledge, authority, and skills to generate specific solutions to the reported challenges.

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1. Further formalize the roles of staff that are responsible for ensuring that in existing cases, children are screened for mental health needs.

2. Improve the process of filling out the mental health screening tool in specific contexts, namely for children 0-5 years of age, for crisis situations and in the medical Hubs.

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1. Improve the ways in which release of information and consent for mental health treatment are obtained.

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2. Reduce delays of reports from the medical Hubs.

3. For Newly Detained Cases:

    a. Consider establishing a system to redistribute MAT slots across SPAs;

    b. Increase MAT provider capacity for conducting assessments in specific SPAs;

    c. Strengthen the protocols (roles, expectations, and processes) for completing the Summary of Findings Report; and

    d. Address the billing issues reported by MAT providers regarding covering the full costs of assessments and service linkage.

4. For Non-Detained and Existing Cases:

    a. Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities; and

    b. Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.

Mental Health Service Provision

1. Increase the understanding of CSWs regarding their role in Child/Family Teams.

2. Strengthen the relationship between CSWs and mental health providers by reducing communication barriers and creating mechanisms to gauge quality of services and outcomes.

3. Address the structural constraints reported by mental health providers that affect their capacity to implement mental health services in accordance with the practice principles stipulated in the Strategic Plan.

Plan Financing and Status of Efforts to Maximize Revenue Reimbursement

Budget Status

The projected full-year cost for the Fiscal Year (FY) 2009-10 Katie A. Budget is $151,746,000 comprised of $84,742,000 in Federal/State revenue and $67,004,000 in Net County Cost (NCC). Currently, it is estimated that there is approximately $8.4 million in NCC savings for FY 2009-10. However, this figure may decline due to several priority initiatives identified in 2009 (i.e., MacArthur Foundation leveraged Child System Treatment and Enhancement Project, SAS Dataflux software, Trauma-Focused Cognitive Behavioral Therapy training, and one-time renovation/equipment related expenses at two Medical Hubs) after the development of the Katie A. Strategic Plan and corresponding budget. Funding for these initiatives was directed to be offset by use of the current year FY allocation for Katie A. This coupled with intensified efforts to boost referrals to Tier II Wraparound, which rolled out in the summer of 2009, should reduce FY 2009-10 savings. A better estimate of current year expenditures and savings will be available in March 2010 at the next Katie A. Quarterly Status Update to the Board.

Efforts to Maximize Revenue Reimbursement

The CEO, County Counsel, and DMH continue to work very closely together to try to maximize revenue reimbursement to the County. Efforts are focused on participation in the negotiations between the Special Master, Rick Saletta, and Plaintiffs'/Defendants' counsel in the State portion of the Katie A. case, in addition to requesting frequent status updates on California's Medi-Cal State Plan Amendment (SPA), which is discussed in more detail below. Currently, Medi-Cal pays for Wraparound services under the Medi-Cal Schedule of Maximum Allowances (SMA). The current SMA does not adequately account for necessary administrative activities (i.e., scheduling meetings, copying materials, document review, etc.) when providing mental health services in a Wraparound setting.

Mediations between the Plaintiffs and the State began in June 2009. In mid-June, the County submitted a letter to Mr. Saletta, which was a follow-up to a County declaration submitted at the request of the Federal Court. The letter to Mr. Saletta provides the County's suggested clarifications to a State DMH All County Letter issued in October 2008, regarding Medi-Cal billing for specialty Mental Health Services, such as Wraparound, provided to children in foster care. The letter provided detailed analyses of where the State has defined reimbursable Medi-Cal activities in an unduly narrow fashion, and further recommends that the State formally adopt the Early Periodic Screening Diagnosis and Treatment (EPSDT) Chart Documentation Manual as the official authority on acceptable standards for documenting EPSDT services (Attachment II). If the State were to adopt the positions taken in the letter, providers of Wraparound services could obtain higher reimbursement without concern about facing repayment obligations on audit.

The meetings between the Special Master, County DMH, Plaintiffs, and State have been occurring weekly since the beginning of the summer. There was a break in the negotiations over the December holidays and the meetings just recently resumed on January 21, 2010. The parties traveled to Los Angeles to have a broader discussion with County representatives regarding the management and funding of Wraparound - related services and the structures/mechanisms that the County has developed for screening, referring, and linking children in the foster care system to mental health services. The mediations led by the Special Master have focused on the following topics:

- Service array and practice development: descriptions of coordinated, comprehensive, community-based services, including access, planning, delivery, and transition;

- System structure and fiscal options: the structure and fiscal system which supports the practices and services model; and

- Quality improvement and education: the standards and methods to achieve quality-based oversight, and develop training and education that support the practice and fiscal models.

The intent of the discussions is to identify the areas of consensus/divergence among the parties and to determine if any compromises can be made regarding the reimbursement of the nine components of Wraparound that the Plaintiffs' attorneys advocate should be Medi-Cal reimbursable service activities. Participants in the negotiations, including our County representatives, have signed confidentiality agreements. It is our understanding, that this phase of the negotiations is drawing to a

close. The Special Master is tentatively scheduled to issue a report to the Court by March 2010, discussing the progress made between the parties and his recommended next steps.

In early October 2009, the County had a conference call with John O'Brien, a Medicaid expert from the Technical Assistance Collaborative that provided expertise to the State of Massachusetts in the Rosie D. lawsuit. Similar to Katie A., the Plaintiffs in Massachusetts filed a civil action against the state based on the lack of medically necessary mental health services which could avert the risk of prolonged or unnecessary hospitalizations or out-of-home placements for thousands of Medicaid eligible children. The Federal Court in Rosie D. ordered Massachusetts to make a number of improvements in relation to the provision of Medicaid-funded EPSDT services, most notably, to provide EPSDT services within a Wraparound-like continuum of care to children with serious emotional disturbance. What we learned from this call is that Massachusetts identified Wrap-related services as a process and not a service activity within their SPA. They created broad service categories (mobile crisis intervention and crisis stabilization; in-home behavioral supports; in-home therapy services; mentoring; and parent/caregiver supports) similar to those advocated by the Plaintiffs in the State Katie A. case. However, as the County has understood, the Massachusetts program focuses on the child's mental health issues, and family services are seen only as an adjunct to such care. Moreover, Federal funding for these services is ultimately subject to the approval of the Centers for Medicare and Medicaid Services (CMS). Some service modalities, such as rehabilitation, have been difficult to define in Massachusetts and have led to ongoing discussions with CMS. The State of Massachusetts has developed operational definitions and detailed service manuals to define coverable service components. This is something that would greatly benefit California and is what the County's June 2009 letter to the Special Master recommended.

According to Mr. O'Brien, the good news is that the climate at CMS is changing for the better; once officials within CMS are educated on the nuances of a service activity, they are generally reasonable. Mr. O'Brien has not seen any state attempt to bundle service activities, which is something the County is interested in. However, it could be a possibility in the future now that there is new leadership at CMS. The bottom line is any change to California's State Plan will take time and there is no silver bullet to address all of the funding issues surrounding the provision of Wraparound services.

The County has communicated with the State on a couple of occasions over the last six months to discuss increasing the SMA rates; the most recent communication was on January 12, 2010. Thus far, the State has been non-responsive to the County's inquiries. If the State is not interested in setting new rates for the SMA, the County's

hands are tied as this issue cannot be broached directly with CMS as the County does not have authority to negotiate directly with CMS. Should that occur, the County would need to seek a legislative approach where the legislature would require the State to set the rate by statute. This, of course, would be much harder to achieve as an increase in SMA would require an additional state general fund contribution.

The proposed mental health services SPA would permit the County to draw down federal matching funds for amounts paid which are above the SMA, and would therefore provide some relief even if the SMA were not increased. From what we understand, the mental health services SPA submitted to CMS in March 2009 has generated complicated requests for additional information (RAIs), from CMS, which are focused on various coverage issues. This process could drag on for months, particularly given the State furloughs. The SPA can be approved retroactively, but will not be effective until the State and CMS resolve the multitude of coverage issues that CMS raised over the summer. Therefore, the County's most viable opportunity to maximize revenue reimbursement for specialty mental health services, such as those provided via Wraparound and which are the costliest service components within the Strategic Plan, is through continued participation in the Special Master mediated negotiations between the Plaintiffs and State. At the January 21, 2010 meeting, the County committed to putting together a list of fiscal, programmatic, legal, and regulatory/administrative barriers effecting the implementation of the Strategic Plan. We will continue to keep you apprised of any progress in these discussions and will continue to inquire with the State the status of the SPA and opportunities for maximizing the SMA.

Summary

A review of first year implementation efforts signify the substantive achievements that occurred in 2009 in implementing the Strategic Plan, as well as the challenges and ongoing work that lies ahead to refine mental health screening, referral, assessment, and service linkage processes for foster children. The CSAT staffing structure implemented in SPAs 7, 6, and 1 and scheduled for Countywide rollout in 2010 was primarily developed to address the deficiencies cited in the HMA report. The fundamental critique identified by HMA that drove the development of the Strategic Plan was the lack of a coordinated vision and model of care guiding systematic processes for mental health screening, assessment, and the provision of timely and appropriate mental health services for children in child welfare.

As articulated in the Executive Summary of the Implementation Evaluation, issues concerning consent for information/treatment, Medi-Cal enrollment/billing issues, competing assessment priorities/deadlines, report delays, service slot shortages, and

inter-departmental tensions are generally known to Project Managers on Katie A. For several of these, corrective actions to improve overall functioning are already underway, and as a result of this report others will be developed. As our knowledge for developing, implementing and refining mental health screening, assessment, and service provisions has evolved, so has the list of obstacles to tackle. We will continually strive to seek solutions to the obstacles impeding our progress. The next Quarterly Status Report will be submitted on March 31, 2010.

If you have any questions, please let me know or your staff may contact Jacqueline White, Deputy Chief Executive Officer at (213) 974-4530 or via e-mail at jwhite@ceo.lacounty.gov.

WTF:JW:SS
KH:LB:yw

Attachments (2)

c: Executive Office, Board of Supervisors
County Counsel
Department of Children and Family Services
Department of Mental Health

Attachment I

Implementation Evaluation Report

Phase One Implementation: *Katie A. Strategic Plan*

Prepared for the County of Los Angeles

Chief Executive Office

Department of Children and Family Services

Department of Mental Health

January 2010

The *INNOVA* Group, Inc.

TABLE OF CONTENTS

Acknowledgements

The *INNOVA* Group, Inc., would like to thank the staff of the Los Angeles County Department of Children and Family Services, Department of Mental Health, and Chief Executive Office who provided guidance with different aspects of this evaluation project and who participated in interviews and focus groups, sharing their experiences and insights on how to improve mental health screening and assessment and mental health service provision for children and youth in the child welfare system in Los Angeles County.

The *INNOVA* Group, Inc., would also like to thank its partners and assistants who helped gather and analyze the information for this evaluation project.

Rigoberto Rodriguez, Ph.D.
The *INNOVA* Group, Inc.
January 2010

I.EXECUTIVE SUMMARY

A. Background

On October 14, 2008, the Los Angeles County Board of Supervisors approved the Katie A. Strategic Plan containing 'a single comprehensive vision for the current and planned delivery of mental health services to children under the supervision and care of child welfare, as well as for those at-risk of entering the child welfare system.'[1] The Strategic Plan seeks to fulfill the objectives identified in the Katie A. Settlement Agreement[2] in two phases over a five-year period. The first phase would be implemented in three Service Planning Areas (SPA): SPA 7 (Santa Fe Springs and Belvedere) started in May 2009; SPA 6 (Compton, Vermont, Waterridge) began in August 2009; and SPA 1 (Palmdale and Lancaster) started in September 2009. The second phase is slated to begin in early 2010 covering SPAs 2, 3, 4, 5 and 8. The Strategic Plan also stipulated that an assessment be conducted of the initial implementation activities to inform the roll out of the plan in the remaining parts of the County.

This evaluation report summarizes the key strengths and challenges in the implementation of two specific components of the Strategic Plan—mental health screening and assessment, and mental health service provision—and it offers recommendations to improve phase two of the implementation. The strengths, challenges, and recommendations identified in this evaluation report stem from information collected in November and early December 2009 about the experiences of line staff and managers from the Department of Children and Family Services (DCFS), the Department of Mental Health (DMH), and Children's Mental Health Providers responsible for conducting mental health screenings, referrals, assessments, and linkages, as well as providing mental health services to children in the child welfare system.

The evaluation project explored four specific components regarding mental health screenings, assessments, and service provision:

1. Mental Health Screenings: What were the strengths and challenges in the efforts to screen all children for mental health needs? How can these efforts be improved?

[1] County of Los Angeles Department of Children and Family Services and Department of Mental Health, Katie A. Strategic Plan, October 2, 2008.

[2] Katie A., et al. v. Diana Bontá, et al. (2003).

2. Referrals to Assessments for Children with Positive Mental Health Screenings: What were the strengths and challenges in the efforts to refer children with a positive mental health screening for an assessment? How can these efforts be improved?

3. Assessments for Children with Positive Mental Health Screenings and Linkage to Mental Health Services: What were the strengths and challenges in the efforts to assess children with a positive mental health screening and to link them to services? How can these efforts be improved?

4. Mental Health Service Provision: What were the strengths and challenges in the efforts to provide mental health services (in accordance with the practice principles stipulated in the Strategic Plan)? How can these efforts be improved?

B. Key Findings

The evaluation project found that the screening and referral processes were the components most successfully implemented in this initial phase. By contrast, the assessment and service linkage processes encountered the greatest challenges. Service provision also faced numerous challenges, but the implementation of this component was too recent in two of the three SPAs to gauge its key strengths and challenges.

The following sums up the specific strengths and challenges of implementing the four components:

1. Mental Health Screening Process

   Strengths: The process put in place to screen for the mental health needs of children in the child welfare system seems robust across the seven sites. The implementation included seven elements that comprise a 'system': (a) an easy-to-use screening tool for mental health needs; (b) practical training on how to administer the screening tool; (c) ongoing formal and informal support on how to fill out the screening tool; (d) explicit protocols and roles specifying who is responsible for filling out the screening tool; (e) multiple checkpoints to ensure that all children have a completed screening tool on file; (f) a data-tracking system that alerts staff members to the status of the child; and (g) cross-system ownership over the early identification of mental health needs.

   The key challenges with the screening process are two: ensuring that all children with existing cases are screened for mental health needs, and administering the mental health screening tool consistently across different and complex, time-limited situations, including the medical Hubs.

2. Referrals to Assessments

Strengths: The process of referring children with positive mental health screenings to assessments also appears to be strong and functioning as a 'system.' Offices have formal procedures for referring cases, clear roles and responsibilities, a checklist of what constitutes a completed referral packet, and a data-tracking system to keep the case moving toward an assessment. The coordinators of the Multidisciplinary Assessment Teams (MAT) and the Service Linkage Specialists (SLS) play instrumental roles in ensuring that the 'packets' required to conduct an assessment are prepared quickly and fully: they participate in Team Decision Making (TDMs) sessions with relevant stakeholders early in the process to focus on the newly detained, non-detained, or existing case; and they are also authorized to access the MedsLite system to accelerate the determination of Medi-Cal eligibility for children.

The key challenges with referring children to assessments are two: obtaining the necessary consent for services in a timely fashion, and determining, obtaining and maintaining benefits for certain children in the child welfare system that are eligible for Medi-Cal.

3. Assessment and Linkage Activities:

Strengths: The Coordinated Service Action Team (CSAT) is viewed as a structure that has brought greater order, efficiency, and accountability to assessment and linkage services for newly detained cases (Track 1) and non-detained and existing cases (Tracks 2 and 3, respectively). CSWs underscored that CSAT brings together staff with special skills, knowledge, resources and networks to ensure that children who are newly detained, non-detained or with existing cases, are appropriately and efficiently assessed and linked to services.

However, in contrast to screening and referral processes, staff members reported encountering a greater number of implementation challenges with assessment and linkage activities.

The key challenges for assessing and linking children to services varied by track and Service Planning Area.

- Track 1 (Newly Detained Cases): Availability of Assessment Slots and Assessment Capacity Issues: In some SPAs, as the providers began to ramp up their staffing to perform MAT assessments, the number of newly detained children needing assessments exceeded the amount of Multidisciplinary Assessment Team spaces

available for assessments; and in some instances, MAT providers responsible for coordinating assessments and linkage lacked the linguistic, cultural, or other capacities to conduct assessments. These issues were particularly present in SPA 1.

- Track 1 (Newly Detained Cases): Difficult Deadlines, Expectations, and Additional Costs: Staff involved with Track 1 cases reported conflicting or unrealistic deadlines for completing the assessments, chronic delays with reports essential to completing the assessments (especially medical Hub reports), inconsistent expectations for completing an assessment (especially the Summary Findings Report), and the inability to cover the full costs of assessment and linkage services.

- Track 2 and 3 (Non-Detained and Existing Cases): Distancing, Roles, and Partnerships: Case-carrying Children's Social Workers (CSWs) involved with non-detained and existing cases reported feeling increasingly distanced from the case and the mental health service providers as the case moved through the assessment and linkage process facilitated by Service Linkage Specialist (SLS) and DMH Co-located staff; Co-located staff stressed feeling that their roles in linking children to services have expanded beyond their skill sets; and Col-located staff also indicated that the collaboration with DCFS has not been entirely conducted as an equal partnership, thus impacting DMH Co-located staff morale.

4. Mental Health Service Provision[3]:

Strengths: All offices expressed confidence that Wraparound services provided mental health services in accordance with the practice principles specified in the Strategic Plan. CSWs and Intensive Social Workers (ISWs) reported that they regularly check in with Wraparound service providers regarding case files.

The three key challenges with mental health service provision centered on non-Wraparound services.

- First, CSWs revealed a lack of clarity concerning their role(s) in Child/Family Teams specified in the Strategic Plan. (It should be noted that the Core Practice Model training curriculum, which will articulate teaming and family engagement

[3] Line staff reported having less experience with mental health service provision. In large part, this is due to the fact that for two of the three SPAs had only just begun implementing the Strategic Plan. Moreover, mental health providers were not part of the focus groups or interviews. Most information about mental health service provision came from CSWs and DMH Co-located staff focus groups, supplemented by a special meeting of the Children's Mental Health Providers Network held on December 2, 2009.

expectations and practices for DCFS, DMH, and contracted mental health providers, is still being developed and has not been implemented yet.)

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C. RECOMMENDATIONS

These recommendations respond to the implementation challenges identified by staff with the screening, referral, assessment and linkage, and service provision activities. These recommendations are presented in the form of goals, rather than specific strategies. The development of specific strategies to address these recommendations, as well as the planning structures needed to arrive at those solutions (for example, committees, timelines, etc.), is outside the scope of this evaluation project and will require bringing together people with the relevant knowledge, authority, and skills to generate specific solutions to the reported challenges.

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3. Address the structural constraints reported by mental health providers that affect their capacity to implement mental health services in accordance with the practice principles stipulated in the Strategic Plan.

D. Report Structure

The report contains five sections.

1. The first section describes the strengths, challenges and recommendations for the process of screening children for mental health needs.
2. The second section describes the strengths, challenges, and recommendations for the process of referring children to assessment and service linkage services.
3. The third section describes the strengths, challenges, and recommendations for the process of assessing and linking children with mental health needs to appropriate services.
4. The fourth section describes the strengths, challenges, and recommendations for mental health service provision.
5. The Appendices provide background information of the following:
    - the evaluation approach and methods, including the limitations of this report;
    - the Strategic Plan's six interlocking goals;
    - the mental health screening and assessment and mental health service provision strategies;
    - the questionnaire used to conduct focus groups and interview;
    - a glossary of terms used in this report; and
    - a reference list of the focus groups and interviews conducted.

II. IDENTIFYING CHILDREN WITH MENTAL HEALTH NEEDS

A. Summary

The activities for mental health screening of children in the County's child welfare system were implemented quite successfully during the first implementation phase.

The screening activities were implemented through a 'system' with seven elements: (a) an easy-to-use mental health screening tool (MHST) that was developed by the California Institute for Mental Health (CIMH); (b) practical training on how to administer the MHST; (c) ongoing formal and informal support on how to conduct the screening; (d) protocols specifying the roles and responsibilities of staff for administering the screening tool; (e) multiple checkpoints to ensure that all files contain a completed screening tool; (f) a data-tracking system to alert staff members to the status of a case; and (g) cross-system ownership of the early identification of mental health needs.

The screening process encountered two challenges. The first challenge is ensuring that all existing cases have been administered a mental health screening. The second challenge is filling out the screening tool consistently in complex and time-limited situations.

B. What Worked Well?

Focus group participants and interviewees felt confident that the screening process put in place to flag the possibility of mental health issues of children currently in or entering the child welfare system is quite strong. The following elements were cited:

<u>The mental health screening tool is simple and easy to use.</u>

- The straightforward, one-page MHST is relatively easy and quick to understand and administer.

- The simplicity of the MHST allows multiple staff to fill out the form completely.

<u>Staff members received training and formal and informal support after the training</u>.

- The MHST trainings were effective, helpful, and were delivered across all the sites to a broad range of staff members involved in screening. Focus groups felt that the mix of DCFS and DMH staff made for a positive environment. The use of hypothetical situations when practicing filling out the MHST allowed everyone to share their reasoning for filling the form out in a specific way, and therefore, participants learned from each other.

- Formal and informal support was provided for CSWs, ISWs and ER workers regarding how to administer the MHST. CSWs and Assistant Regional Administrators noted that after the initial trainings, mini-trainings were held for the DMH Co-located staff and DCFS staff to broaden their understanding of the MHST. DMH Co-located staff and DCFS staff members have continued this collaboration. Two offices have implemented monthly meetings involving CSWs, SLS, MAT Coordinators, and DMH Co-located staff. These meetings are used to answer any questions regarding the MHST, and address any issue that arises.

- A noticeable amount of informal support was also provided to CSWs. DMH Co-located staff members have been a source of information and assistance for CSWs and ISWs. This assistance was provided on a case-by-case basis and the level of assistance varied by site.

<u>All offices have procedures for administering the MHST</u>.

- Although there are some differences in procedures among offices, they generally follow a similar pattern. For new cases, the MHST is completed at the first point of contact, during the investigation and/or the medical screening. The first person responsible for completing the MHST varies by office, but generally this person is the ER worker, CSW, ISW or staff at the medical Hub.

- Existing cases are reviewed by the CSW or ISW at the time of an incident or at the next case plan update. The Regional Administrator and Assistant Regional Administrators have been responsible for selecting which staff will be responsible for completing the MHST and related documentation. There is flexibility in the policy for each office to establish certain protocols that best fit the needs of the office.

<u>There are multiple checkpoints in the system to verify that children have been screened for mental health needs.</u>

- For children entering the child welfare system, as newly detained or non-detained, there are numerous points where the MHST is reviewed for completion. For example, medical Hub staff complete the MHST for all newly detained children who go to a Medical Hub, then faxed to the regional office where it is reviewed by the CSW, SCSW, and SLS or MAT Coordinator. For all other children, the MHST is completed by the CSW, reviewed by the SCSW, and transferred to the SLS or MAT Coordinator to review, track, and take necessary follow-up action regarding service linkage. In addition, the MHST is often

completed at the TDM, so this provides another level of review and/or opportunity for input.

- If the mental health screening comes back negative at the point of entry into the child welfare system (i.e., newly detained or non-detained cases), a second opportunity to screen for the child's mental health needs exists at the time of the case plan update, if any behavioral indicator on the MHST is observed, or if there is an incident with the child.

- For children with existing cases who have not previously had an MHST screening, a review is conducted at the next case plan update or at a time of a behavioral indicator or incident. If the CSW does not conduct the screening at the six-month point, the SCSW/SLS functions as a checkpoint to ensure that every child has been screened for mental health needs.

The data tracking system keeps staff members connected and fosters accountability regarding mental health screenings.

- The data-tracking system helps keep staff connected concerning the mental health needs of children with positive screenings, allows for transmission of information and files from one point in the system to another, and allows multiple entities access to data about the children with positive screenings.

- For example, CSWs reported that the SLS is able to send them messages on the status of cases that are nearing specific deadlines. Communication is carried out via emails, phone calls, and in person. This combination of communication strategies allowed staff members to get the most accurate and updated information on the case, while providing an open line of communication on any issues that might delay sending the file to the SLS or MAT Coordinator. They indicated that this was very helpful in keeping track of deadlines and monitoring cases.

There is enhanced cross-system ownership of the identification of mental health needs of children in the child welfare system.

- ER workers, CSWs, and medical Hub workers reported having a greater awareness of the need to identify the mental health needs of children in the child welfare system. They indicated being more able now to identify symptoms more quickly upfront. The trainings have helped CSWs better explain to parents or caregivers about the various mental health services and ease any of their concerns. Many ER workers also revealed that a shift had occurred in their thinking, where a child's mental health needs was on par with ensuring the safety and welfare of the child and no longer an afterthought.

C. What Were the Challenges?

Ensuring that all existing cases have been administered a mental health screening.

- Staff members did not explicitly raise concerns that existing cases are not receiving mental health screenings. Rather, the evaluation team is raising this as a possible challenge based on two observations.

    - First, unlike the newly detained and non-detained cases entering the system, the existing cases have fewer checkpoints to catch if a mental health screening has not been conducted. Currently, as reported via the focus groups and interviews, if a CSW or ISW does not complete an MHST during an incident or at the six-month review point, the only person who would catch this omission is the SCSW.

      However, the SCSW focus groups consistently reported a spike in the workload during the first six months of implementing the screening activities, and indicated feeling overwhelmed with the amount of work because during the first six months all the cases are reviewed in accordance with the six-month case update policy. The workload on the shoulders of the SCSW during these six months can weaken their ability to ensure that all children who need an MHST administered actually have a completed MHST on file.

    - Second, the evaluation team understands that another staff member, the RTS, functions as a safeguard on this issue because the RTS can catch if a case has gone without an update and alert the CSW or SCSW. However, focus groups participants and interviewees did not mention that the RTS formally checks the file for the completion of a MHST. The evaluation team is raising this is as a concern just to be sure that such a role is formalized to strengthen this checkpoint to ensure that existing cases are administered a MHST.

Administering the MHST consistently under complex circumstances.

- Children 0-5: DCFS staff members reported being comfortable using the MHST with children over the age of five because symptoms seem clearer and the ability to speak with the child can help flag the possibility of mental health needs. However, staff indicated that identifying symptoms for children under five is more difficult, in part, because the symptoms may not be visible or the inability of children in that age group to express themselves, among other reasons. This situation has led some staff members to record 'unknown' in certain parts of the MHST. Although marking unknown is not in itself a problem, it automatically triggers a full assessment conducted via MAT or Co-located

staff. DMH Co-located staff members indicated that many of the children under five with 'unknown' on the MHST end up being false positives for mental health problems.

- Crisis Situations: ER workers reported having difficulty completing the MHST when they are working with a family and/or child in a crisis situation, such as cases of immediate removal (24-hour period) and five-day referrals. ER workers pointed out that a crisis will tend to affect a child's behavior in the short term (24-hour period or five-day referral), but their behavior may have substantially changed after this five-day period, that is to say, by the time the child is seen at the TDM or for a full assessment. ER workers noted that they do not typically have enough time to observe the child nor do they have the mental health skills to understand the significance of the child's symptoms displayed during the crisis. (This is situation is exacerbated with children under five years of age.)

- Medical Hubs: CSWs pointed out that screenings conducted at the medical Hubs were less likely to result in a positive assessment. CSWs also reported that some medical Hub staff members indicated they have experienced difficulties completing the MHST. Other DCFS managers, moreover, noted that MHST positive results vary across medical Hubs.

D. RECOMMENDATIONS

- Strengthen the checkpoint with existing cases to ensure that a MHST is administered. Consider formalizing the RTS' role with regards to checking for the completion of an MHST with existing cases during the course of case updates.

- Improve the process of filling out the MHST under difficult circumstances. Consider enhancing the training by adding additional information and strategies on how to fill out the MHST when working with children 0-5 and in crisis situations. The DCFS Training staff also recently provided MHST training to all medical Hub staff to improve the accuracy in the completion of the screening tool at the medical Hubs.

III. REFERRING CHILDREN WITH POSITIVE SCREENINGS FOR AN ASSESSMENT

A. Summary

The process of referring children with positive mental health screenings to full assessments is also strong. Strengths include a clear understanding of the referral packet requirements; formal referral procedures; MedsLite system to determine Medi-Cal eligibility; and the data-tracking system to facilitate referral flow.

The key challenges with referring children to assessments are two: gathering the appropriate consent for services in a timely fashion and establishing or maintaining Medi-Cal eligibility for certain children in the child welfare system.

B. What Worked Well?

Formal referral procedures.

- Each office has procedures ensuring that positive screenings for newly detained or non-detained children are referred to the SLS or MAT Coordinator for assessment. The procedures include personally handing over the file boxes containing case files directly to the clerk, SLS, or MAT Coordinator.

- All offices also use email or phone calls to inform the CSW that the assessment has been scheduled or to communicate any other issues with the file that must be cleared up before the case can be assessed. For each case, CSWs and ISWs are aware of the items needed to make a referral.

Clear Lines of Responsibility and Supportive Roles

- The CSW is responsible for tracking the case throughout the system and for completing the packet with the documentation needed for the assessment.

- However, most offices also reported that the MAT Coordinator or SLS actively assists the CSWs with completing the packet in order to expedite the file.

- In preparing the packets, the assistance of the MAT Coordinator and SLS is largely informal and depends on their proactive approach. The assistance is also dependent on the number of files and workload pressure of the MAT Coordinator and that person's specific role at each site.

Clear Understanding of Referral Packet Requirements

- There is a formal checklist of items that must be completed and must be in the referral packet before the case can move to the assessment stage.

- Elements of the packet include: ER investigative material, CSW findings, court documentation, TDM information, Hub report, benefits establishment (Medi-Cal), MHST and consent (release of information and consent for services).

- The trainings provided to staff and the post-training support included information about what a complete referral packet must contain.

The Data-Tracking System Facilitates the Flow of Referrals

- The MAT Coordinator and SLS use the data-tracking system to move the referral from the CSW to the assessment.

- SCSWs and other managers indicated SLS and MAT Coordinators are using the data-tracking system to track referrals before the file has been officially handed over.

- Cases might be returned to the CSW if there is a change in Medi-Cal status or consent, suggesting that when files are missing information, staff in other parts of the process flag the issue.

MedsLite accelerates the process of determining if a child is eligible for Medi-Cal.

- In the past, DCFS staff members relied on non-DCFS staff for printouts that confirmed Medi-Cal status. Determining Medi-Cal eligibility is essential in terms of accessing services. CSWs and ISWs rely on MedsLite to determine Medi-Cal eligibility. MedsLite allows users to view the Medi-Cal status of a child and print a confirmation page.

- Recently, MAT Coordinators and Service Linkage Specialists have been trained and authorized to access MedsLite to verify Medi-Cal eligibility.

- Staff members from all offices stated that DCFS staff members' ability to access MedsLite has substantially shortened the turnaround time to determine Medi-Cal eligibility.

C. What are the Challenges?

Obtaining consent for information and treatment is a complicated process

Obtaining consent for information and consent for services is a complicated process that can delay the completion of the referral packet.

Consent	Issues
Parent or legal guardian	Timing for consent is crucial because parents or guardians might not want to sign if they are emotionally stressed or upset, feel that mental illness is a stigma, or they are mistrustful of the department. Finding the parent or legal guardian to sign the consent form can be difficult. The parent or guardian might be unable to sign because the form may not be available in languages other than English.
Children twelve years or older	In some instances, CSWs will include consent from a child who is twelve years or older in order to move the referral process along. Consent granted by children twelve years or older is not always accepted by providers or DMH Co-located staff for assessment or service provision.
Courts	When the courts use standardized language on a minute order, it speeds up the completion of the case packet and referral, but the court's language on minute orders has not been standardized across the system. When minute orders do not use the correct language or are too specific, this can delay the referral process. In some cases, attorney orders are easier to obtain in the short term, but attorney orders are not always accepted by DMH or service providers.

Establishing and maintaining Medi-Cal benefits can also be a complicated process.

Three different situations emerged from focus groups and interviewee.

Situation 1: The child is not eligible for Medi-Cal.

Some children with positive screenings do not qualify for full-scope Medi-Cal. Although children who are not Medi-Cal eligible are not members of the Katie A. class, CSWs are in a situation where they need to conduct an assessment for children who have positive screenings. In some cases, a child might qualify for emergency Medi-Cal, but that type of Medi-Cal is not accepted by most service providers. Resources for these cases vary by SPA but are generally limited.

Situation 2: The child is enrolled in private insurance or HMO Medi-Cal

Children enrolled in private insurance programs or HMO Medi-Cal need to be dis-enrolled from their current medical provider and enrolled in full-scope Medi-Cal. The process of disenrollment can take more than a month if the parent or caregiver is hesitant to make the change.

When children have private insurance or HMO Medi-Cal, the CSW works with the caregiver and County representatives to dis-enroll the child and enroll the child in full-scope Medi-Cal. CSWs report that private insurance medical providers can be quite uncooperative. For instance, CSWs noted difficulties in obtaining information and records about children enrolled with private medical service providers.

When the child is not able to enroll in full-scope Medi-Cal and must remain under the current insurance provider, the CSW works with the medical providers to obtain mental health services for the child.

The issues associated with dis-enrollment cause delays.

Situation 3: The child is placed outside of Los Angeles County

Placing children outside the County reportedly occurs most often in cases where offices are located near the boundaries of Los Angeles County. When children are placed with a family or foster-care parents residing in a different county, the CSW coordinates the service provision with a provider that accepts Los Angeles County full-scope Medi-Cal. In such cases, it is the responsibility of the CSW to link the child to services.

However, out-of-county providers do not always accept certain types of Medi-Cal. The child must be enrolled in full-scope Medi-Cal offered by the county where the child is placed.

In these cases, the child tends sees a delay in services while they are transferred to a service provider outside of Los Angeles County.

Establishing these types of out-of-County Medi-Cal issues can also delay a case one to two months, if not longer.

D. RECOMMENDATIONS

- Improve the process of obtaining consent from various parties to decrease delays in starting the assessment.

- Strengthen the process of determining eligibility and obtaining Medi-Cal for those who are eligible.

- Accelerate the dis-enrollment process for children with private insurance or HMO Medi-Cal and for children placed outside of Los Angeles County.

IV. ASSESSING AND LINKING CHILDREN WITH POSITIVE MENTAL SCREENINGS

A. Summary

The Coordinated Service Action Team (CSAT) was viewed as a structure that has brought greater order, efficiency, and accountability to assessment and linkage services for newly detained cases (Track 1) and non-detained and existing cases (Tracks 2 and 3, respectively). CSWs underscored that CSAT is a structure that brings together staff with special skills, knowledge, resources and networks to ensure that children in Track 1 (MAT Program) or Tracks 2 and 3 (SLS and DMH Co-located) are appropriately and efficiently assessed and linked to services.

However, in contrast to screening and referral processes, staff members reported encountering a greater number of implementation challenges with assessment and linkage activities. The key challenges for assessing and linking children to services varied by track and Service Planning Area, and revolved around three issues: (a) availability of assessment slots and assessment capacity issues; (b) difficult deadlines, expectations, delays and costs; and (c) distancing, roles and partnerships.

B. What Worked Well?

A Strong Process for Newly Detained (Track 1) Children

- The MAT Coordinator is responsible for finding a MAT Provider with an open time slot for an assessment within a certain timeframe.
- The MAT provider is responsible for coordinating and facilitating the MAT assessment, which includes interviews, education information, caregiver information, placement information and concerns, and a Hub report.
- A Summary of Findings Report is created and submitted to the CSW for review and approval.
- After the Summary of Findings Report has been approved, the MAT provider, CSW, or MAT Coordinator focus on linking the child to services.
- DCFS and DMH collaborate in specific instances where there is a backlog of children waiting for a slot for a MAT assessment. DMH Co-located staff have helped perform a mental health assessment and provided mental health services while a MAT slot is identified.

A Strong Process for Non-Detained (Track 2) and Existing Cases (Track 3)

The SLS is responsible for working with the DMH Co-located staff within a specific timeframe to provide a mental health assessment, treatment, and/or service linkage to the DMH provider network.

If urgently needed service capacity is not available within the DMH provider network, the DMH Co-located staff will provide mental health services to the child while a provider is found to conduct a mental health assessment and/or to provide treatment.

C. What are the Challenges?

Track 1: Newly Detained and Specific SPAs

Availability of Assessment Slots and Assessment Capacity Issues:

- In some SPAs, as the providers began to ramp up their staffing to perform MAT assessments, the number of newly detained children needing assessments exceeded the amount of Multidisciplinary Assessment Team spaces available for assessments.
- In some instances, MAT providers responsible for coordinating assessments and linkage lacked the linguistic, cultural, or other capacities to conduct assessments.

Difficult Deadlines, Expectations, Delays and Costs:

- Even when MAT slots are available or MAT providers have the capacity to conduct the assessment, CSWs report that they regularly have to ask the court for extensions in order to comply with the requirements of the case.
- For instance, the court schedules a detention hearing 15 days after detainment. Follow-up reports are based on the court's timeframe.
- However, a medical Hub report has a timeframe of 30 days.
- The completion of the assessment—, which includes the medical Hub report—has a completion time frame of 30 to 45 days.
- Frustrations were expressed with the Summary of Findings Report, which is needed in order to conclude the MAT assessment. Completing this report is difficult for several reasons. For example, the CSW and caregiver must review and approve the Summary of Findings Report, but they often reject based on range of minor or major problems. CSWs can also reject the Summary of Findings Report if it does not contain any new

information or is lacking information that might be critical in deciding the course of action for a child.

- CSWs in different offices apparently apply different standards for accepting or rejecting the Summary of Findings Report. If the MAT Provider has to re-write the Summary of Findings, this adds to more costs to the process.

- Staff members from various offices also stated that the Summary of Findings Report rarely included the medical Hub report because it does not tend to arrive on time for MAT assessments.

Tracks 2 and 3: Non-Detained or Existing Cases

The use of SLS and DMH Co-located staff places greater distance between the CSWs and the mental service providers.

- CSWs generally characterized this situation as a mixed blessing or a paradox. On the one hand, CSWs recognize the positive aspects of having the SLS, DMH Co-located, and MAT Coordinators and MAT Providers specialize in screening, assessment, and linkages.

- On the other hand, the introduction of CSAT means that CSWs are not as active in creating and maintaining a direct connection to mental health service providers.

- At the same time, CSWs reported not having clear communication protocols to keep the CSW in the loop with the case during the assessment and linkage process.

DMH Co-located Staff Expanding Roles beyond Expertise, Skills, and Networks

- DMH Co-located staff (and mental health contract providers) indicated that in some cases when conducting mental health assessments and linkages, they routinely facilitate referrals and linkages beyond their field of expertise.

Not working as equal partners.

- In different offices across the SPAs, DMH Co-located staff expressed feeling that DCFS staff members treat them as people who work for DCFS rather than treating them as equal partners.

D. RECOMMENDATIONS

- Align the various deadlines for completing assessments.
- Reduce delays of reports from the medical Hubs.
- For Newly Detained Cases:
  - Consider establishing a system to redistribute MAT slots across SPAs.
  - Increase MAT provider capacity for conducting assessments in specific SPAs.
  - Strengthen the protocols (roles, expectations, processes) for completing the Summary of Findings Report.
  - Address the billing issues reported by MAT providers regarding assessments and service linkage.
- For Non-Detained and Existing Cases:
  - Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities.
  - Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.

V. PROVIDING SERVICES TO CHILDREN WITH MENTAL HEALTH NEEDS

A. Summary

The successes and challenges with mental health service provision were the most difficult to gauge through this implementation evaluation study, primarily because the implementation experiences were so recent in two of the three SPAs. In addition, the Core Practice Model training curriculum, which focuses on the practice principles including Child/Family Teams, had not been completed or delivered to DCFS or DMH staff.

The evaluation nevertheless asked staff to share their views and experiences (limited as these may be) about the strengths, challenges, and recommendations regarding mental health service provision. All offices expressed confidence that Wraparound services provided mental health services in accordance with the practice principles specified in the Strategic Plan. CSWs and Intensive Social Workers (ISWs) reported that they regularly check in with Wraparound service providers regarding case files.

The key challenges with mental health service provision centered on mental health services delivered via a non-Wraparound approach. The key challenges revolved around the CSWs' understanding of their role in Child/Family Teams and the absence of formal, cross-agency teaming mechanisms; and the multiple constraints that mental health providers felt impinged on their ability to deliver mental health services in accordance with the practice principles in the Strategic Plan.

B. What Worked Well?

Wraparound Services Are Consistent with Core Principles

- Participants in the focus groups and the interviews felt that Wraparound services were consistently implementing the Strategic Plan's practice principles. When slots are available, Wraparound liaisons begin contact with children within a week of referral. Wraparound is able to provide services consistent with the core principles because it has been in existence longer, and staff know what these providers do and how they do it. This helps CSWs and others understand the referral process. Strong Wraparound liaisons have been instrumental in engaging in a dialogue with DMH Co-located staff members and the CSWs, which enhances communication concerning referred children.

- The Wraparound liaisons are consistently involved in the Team Decision Making (TDMs) and assessments. This allows CSWs and other staff members to build a relationship and create an understanding with Wraparound service team members. This relationship

assists the CSWs in gauging the quality of service as well as more accurately updating the status of children receiving services.

CSWs and ISWs regularly check in with service providers to update case files and to meet court requirements in cases of detention.

- CSWs are contacting service providers in a timely fashion to obtain information on children participating in mental health services. In most instances, service providers are able and willing to discuss a child and provide updates, within the boundaries of confidentiality.

- The reports contain information on the number of sessions a child has attended and if the child has reached certain milestones. Updates from the service provider are crucial for meeting court and file maintenance requirements.

C. What were the Challenges?

Case-carrying Children's Social Workers (CSWs)

Little Awareness of Practice Principles and Roles.

- CSWs were generally unaware that they should play a central role in creating Child/Family Teams. (This is understandable, of course, because the Core Practice Model training has not been provided.)

- However, a number of CSWs reported not being involved as a team member in a Child/Family along with the mental health service providers.

Weak Cross-Agency Teaming Structures

- CSWs indicated that most of the communication between them and mental health providers tends to revolve around court-mandated reports or file updates with existing or non-detained cases. They also indicated that in many cases, the reports do not contain qualitative information.

- They also cite confidentiality rules as a barrier to accessing qualitative information beyond what is court-mandated. Confidentiality issues occur. Distance between the CSW and the provider heightens that problem.

- Many times the information the CSW obtains is incomplete or inadequate to satisfy reporting requirements. CSWs monitoring of cases is largely driven by the need to report back to the court.

Children's Mental Health Providers

Substantial Budget Cutbacks to Mental Health Providers

- Agencies have experienced substantial budget cuts, and agencies have responded by cutting staff positions, adjusting job duties, and/or moving staff to different positions. The cutbacks affect their ability to match staff skills with children in need of mental health services. As cutbacks occur and staff turnover kicks in, linguistic and cultural capacity diminishes.

Training Needs

- Service providers spend a lot of time training staff members and bringing them up to speed, only to have those employees either leave the organization or change positions. Service providers noted that universities are not training workers in the now-required skills sets, which places greater responsibility on the service provider to train employees.

Lack of Buy-In at All Levels:

- Service providers indicated that it is difficult to implement the core principles of the Strategic Plan without the buy-in of staff at all levels, including administrative ones. Service providers stated that they have observed different rates of participation and varying magnitudes of understanding at all levels, including administrative ones. They feel they are not receiving clear messages about goals, clear instructions on how to conduct their work, and even billing requirements. Service providers believed that there needed to be more of a focus on buy-in by supervisors and Area Regional Administrators because the latter can impact the culture and the actions in an office.

D. RECOMMENDATIONS

- Increase awareness of CSW's role in Child/Family Teams and the Core Practice Model.
- Strengthen the mechanisms for cross-agency collaboration between the CSW and the service provider
- Address the structural challenges faced by the mental health provider particularly training issues, staff turnover, and other issues identified by mental health providers.

VI. CONCLUSION: NEXT STEPS

This evaluation project found that the screening and referral processes were the components most successfully implemented in this initial phase. By contrast, the assessment and service linkage processes encountered the greatest amount of challenges. Service provision also faced quite a few challenges, but the implementation of this component was too recent in two of the three SPAs to gauge its key strengths and challenges.

As the Department of Children and Family Services and Department of Mental Health consider how to address the recommendation contained in this report, a useful way of addressing these recommendations is by organizing them into three areas: practice protocols; training; and policy. (Some recommendations can fall into more than one category.)

Practice Protocols: Some of the recommendations may require modifying or formalizing roles and expectations. These decisions can be made by department leadership.

Component	Recommendations
Screening	• Further formalize the roles of staff who responsible for ensuring that in existing cases children are screened for mental health needs.
Referrals	• Improve the ways in which release of information and consent for mental health treatment are obtained.
Assessment and Linkage	• Reduce delays of reports from the medical Hubs. • Strengthen the protocols (roles, expectations, processes) for completing the Summary of Findings Report. • Address the billing issues reported by MAT providers regarding covering the full costs of assessments and service linkage. • Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities. • Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.
Service Provision	• Strengthen the relationship between CSWs and mental health providers by reducing communication barriers and creating mechanisms to gauge

quality of services and outcomes.

Training: Some recommendations are probably best addressed as training issues.

Component	Recommendations
Screening	• Improve the process of filling out the mental health screening tool in specific contexts, namely for children 0-5, for crisis situations, and in the medical Hubs.
Referrals	• Improve the ways in which release of information and consent for mental health treatment are obtained.
Assessment and Linkage	• Reduce delays of reports from the medical Hubs. • Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.
Service Provision	• Increase the understanding of CSWs regarding their role in Child/Family Teams.

Policies: Other recommendations may require a change in formal policy at different levels.

Component	Recommendations
Screening	Minimize the problems of Medi-Cal enrollment and disenrollment, particularly for children with private insurance, HMO Medi-Cal, or placements outside Los Angeles County.
Referrals	• Improve the ways in which release of information and consent for mental health treatment are obtained.
Assessment and Linkage	• Align the various deadlines for completing assessments. • Consider establishing a system to redistribute MAT slots across SPAs.
Service Provision	• Address some of the structural conditions reported by the mental health providers, such as the issues of funding gaps.

VII. APPENDICES

A. Evaluation Research Approach and Methods

The implementation evaluation focused on the successes and challenges encountered during initial implementation of the Strategic Plan in order to provide recommendations on how to improve implementation in the remaining parts of the county. This research project used a formative evaluation approach, which seeks to understand the contextual factors that affect the implementation of a program or initiative. Contextual factors can include organizational dynamics, roles and processes, and funding, to name just a few components.

The evaluation project focused on the experiences of DCFS and DMH staff responsible for implementing two components of the Strategic Plan: the mental health screening and assessment and mental health service provision (Appendix 3). Data for this evaluation project came from 27 focus groups, seven each with case-carrying Children's Social Workers (CSWs), Coordinated Service Action Teams (CSATs), and Supervising Case Social Workers, and six with DMH Co-located staff. Additionally, 18 individual interviews were conducted with Regional Administrators, Area Regional Administrators, District Chiefs, and Program Heads. Additional information was gathered during a special meeting of the Children's Mental Health Providers Network.

The questionnaire (Appendix 4) for the focus groups and interviews was organized into four sections: screening, referral, assessment and service linkage, and service provision activities. Each section contained three anchoring questions: What is working well with the implementation? What challenges have been encountered during implementation? What recommendations do you have to improve the implementation? Each anchoring question had additional probing questions.

The information gathered was coded into themes according to the relevant section, anchoring question, and focus group or interview type. For example, information from the case-carrying Children's Social Workers across seven sites about the challenges with the screening process were brought together and coded by themes.

The strength of these qualitative research methods is that the researchers heard directly from those who are implementing the Strategic Plan objectives pertaining to mental health screenings and assessments and mental health service provision. However, the evaluation methods possessed a critical limitation: the information collected was primarily based self-reporting.

To strengthen the validity of the information, the evaluation team ran27 focus groups (27) and conducted 18 interviews. In most cases, seven focus groups were facilitated with the same group (for example one CSW group across seven sites).

The evaluation researchers sought to validate the data by applying two criteria. The first criterion was repetition: if two or more groups—or two or more people in the same group—mentioned the same strength, challenge, or recommendation within a particular process

(i.e., screening, referral, assessment and service linkage, or service provision), the item was turned into a theme.

A second criterion for creating a theme was whether an issue had a bearing on a system. If an issue was presented only once but it was relevant to a system, it was turned into a theme. An example of this is the MedsLite system. The introduction of the MedsLite system was mentioned once during the interviews, but this item has a major impact on the referral process because it accelerates the determination of Medi-Cal eligibility, which is critical in terms of moving a case to the assessment stage.

These two criteria (i.e., repetition and system impact) were also used to develop recommendations. The researchers developed recommendations by starting with recommendation explicitly offered by focus group participants and interviewees. Emphasis was placed on those recommendations that were presented several times and across sites. However, in cases where a pattern of challenges crystallized across several sites but no one presented a corresponding set of recommendations, the researchers developed the recommendations.

It is important to point out that this report's recommendations are not the same as solutions. The recommendations are framed as goals that will require identifying the specific strategies or solutions at a later point. Although the focus group participants and interviewees offered specific ideas and solutions to resolve particular problems, it was beyond the scope of this project and the expertise of the researchers to vouch for the validity or viability of the proposed solutions. Instead, the researchers captured the range of ideas presented as recommendations and can make these ideas available upon request as this process moves into the next stage of identifying concrete solutions to assist with the roll out of the Strategic Plan in the remaining SPAs.

B. Katie A. Strategic Plan Goals

The Katie A. Strategic Plan is comprised of six interlocking goals:

1. Mental Health Screening and Assessment – Ensure mental health screening and assessment for 100% of children formally and informally entering foster care, as well as those already receiving child welfare services.

2. Mental Health Service Delivery – Provide the most timely and individualized mental health services to children to promote stability of placements or prevent removals from home.

3. Funding of Services - The County is refocusing their energies and prioritizing strategies utilizing the Title IV-E funds, EPSDT dollars, and MHSA FSP slots to fund the mental health services needs for the Katie A. class members.

4. Training - The November 2006 Order from Judge Matz reiterated the Panel's concerns from their Fifth Report to the Court indicating that efforts to train staff fall short of the intended objectives because trainings do not impart the foundations of good practice—engaging families, effective teaming and coordination, thorough assessment of strengths and needs, individualized planning, and effective interventions. The Court directed the County to obtain feedback from DCFS and DMH workers to better inform needed enhancements to the training curriculum.

5. Caseload Reduction - Although caseload reduction is not a mandated component of the Katie A. Settlement Agreement or 2006 Court order, DCFS senior managers, in concurrence with the Katie A. Panel, view reduced caseloads as a vital objective necessary to execute the objectives of the Katie A. Settlement Agreement and subsequent orders.

6. Exit Criteria and Formal Monitoring Plan - The 2006 Order from Judge Matz tasked the County with developing measurable exit conditions and monitoring criteria, in order to demonstrate unequivocally that the County has fulfilled the provisions of paragraphs 6 and 7 of the Settlement Agreement.

C. KATIE A. STRATEGIC PLAN: MENTAL HEALTH SCREENING AND ASSESSMENT AND SERVICE PROVISION

The Katie A. Strategic Plan's Mental Health Screening and Assessment and Mental Health Service Delivery goals' implementation is designed in the following manner:

Mental Health Screening and Assessment

The goal of this component is to ensure the mental health screening and assessment of 100% of children formally and informally entering foster care, as well as those already receiving child welfare services. To achieve this goal, three tracks were established to screen and assess children in foster care.

Track One: Emergency response referrals resulting in detention

- All newly detained children receive a comprehensive mental health assessment and linkage to service through the Multidisciplinary Assessment Team (MAT) Program, within 45 days of being detained.

- MAT assessments focus on the following key areas: mental health; physical health; developmental milestones; hearing/language development; caregiver/family of origin; and educational and vocational needs.

- Medical evaluation is conducted at a medical Hub or by a community medical provider. The comprehensive evaluation must be performed within 72 hours of detention, if a high-risk case, and30 days for all others.

Track Two: Emergency response referrals resulting in a non-detained, open case (family maintenance or voluntary family reunification)

- All will receive mental health screening by the case-carrying Children's Social Worker.

- The Mental Health Screening Tool (MHST), developed by the California Institute for Mental Health (CIMH), will be used to administer the screening. The MHST was developed for non-clinicians, and it requires little formal training to use and can be administered quickly.

- If the screening is positive, link to appropriate services through DMH Specialized Foster Care Co-located Staff (if EPSDT eligible) or through a DCFS Service Linkage Specialist.

- Protocols for conducting the screening will be developed.

Track Three: All Existing/Open Cases

- The case-carrying CSW will complete the CIMH MHST when the next case plan update is due.

- Exceptions include children with a previously completed MHST; children already receiving mental health services; and children receiving D-rate placements.

- A subsequent screening is required upon identification of a behavioral indicator.

The infrastructure to support and expedite screening and assessment activities include:

Coordinated Services Action Team (CSAT)

- New administrative and teaming structure within each DCFS office to align and coordinate DCFS and DMH non-line staff to rapidly provide screenings and/or referrals and ensure service linkage.

- CSAT is comprised of DCFS, DMH, DPH, and DPSS staff (Team Decision Making staff, Multidisciplinary Assessment Team staff, Resource Utilization Management (RUM)/Resource Utilization Management Process (RMP) staff, D-Rate, Wrap, public health nurses, educational liaisons, Service Linkage Specialists, Youth Development Specialists, Permanency Partners Program (P3) staff, Adoption Safe Families Act staff, Specialized Foster Care staff, and Linkages co-located staff).

- Align and integrate siloed services/programs into CSAT—protocols delineating respective operational responsibilities for CSAT staff under development.

Team Decision Making (TDM)

- TDM is a meeting process teams up family, community partners, service providers, support networks, and facilitators to make decisions concerning a child's safety and placement, particularly in relation to a child's removal, re-placement, or return home.

- TDM facilitators are integrated into CSAT.

Resource Utilization Management Process (RMP)

- The focus is to transition children out of congregate care through a coordinated care approach to meet the needs of children currently in, or at risk of, placement in a RCL 6 – 14.

- Child and Adolescence Needs and Strengths (CANS) tool administered by DCFS RUM staff and DMH psychologists to determine the most appropriate placement/services.

- RUM staff and DMH psychologists are integrated into the TDM and CSAT structures.

Family Centered Services Referral Tracking System

- The referral form will allow some case-identifying and demographic information to be pre-populated and forwarded to CSAT for service linkage and follow-up.

- First phase would entail flagging DCFS referrals with special projects code, which would be uploaded regularly to DMH. Referrals would be matched against DMH billing codes to provide a service receipt dispositional report, which would not allow for case management but would provide the basics to track service provision.

- Second phase would be for DMH to build a case management application in which information could be entered, copied, and pasted back in CWS/CMS.

Mental Health Service Delivery

The goal is to provide the most timely and individualized mental health services to children to promote stability of placements or prevent removals from home.

To achieve this goal, practice principles were established requiring a team approach to deliver Intensive Home-Based Services that require (1) a strength-based approach for serving families; (2) a multiagency collaborative team approach; and (3) services that are responsive to cultural context and family characteristics.

Child and Family Teams (CFTs) operate with a facilitator, who ensures adherence to the practice principles, and a Parent Partner, former primary caretaker of children, who generally acts as an advocate and resource coordinator for the family.

CFTs are grounded in a Wraparound approach of doing "whatever it takes" to serve the families.

D. QUESTIONNAIRE

Katie A. Strategic Plan: Formative Evaluation: Questionnaire

I. **INTRODUCTION** [Approximately 5 min or less]

- Welcome and thank you for attending this focus group.
- My name is [ ] and I will be facilitating this focus group.
- This focus group is scheduled to last approximately 1 hour and 15 minutes.
- As you may know, the Katie A. Strategic Plan intends to provide [OPTIONAL: this could be on a flipchart]:
    - '... a single roadmap for the implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement to be accomplished over a five-year period...' (Katie A. Implementation Plan Quarterly Updates, 9/30/09).
- SPAs 1, 6, and 7 were the first ones to begin implementing the Strategic Plan. The Plan will be rolled out across the remaining SPAs over the course of 2010.
- The purpose of this focus group is to learn from you about HOW the implementation of the Katie A. Strategic Plan is going at your site.
- Your experiences and insights are critical because what we learn from these focus groups will help shape how the implementation process is adjusted and shaped for the current and upcoming SPAs.
- To get a well-rounded perspective, we are conducting focus groups with CSWs, SCSWs, CSAT members, DMH Co-located Staff; and we are also conducting interviews with Regional Administrators, Assistant Regional Administrators, District Chiefs and Program Heads.
- IMPORTANTLY, we are not here to evaluate anyone's INDIVIDUAL performance. Rather, we are here to get a grounded understanding—based on your experiences—of how the implementation systems, processes, protocols, and roles are working.

II. GETTING STARTED [Approximately 5 min or less]

- Let me review three things in order to get us started with the focus group.
- FIRST, we want to record this conversation so that we can capture the nuances of what you say. The recording will stay with us, The INNOVA Group, until we complete this study (January 30, 2009).
- We will dispose of the digital recordings at that time. We will type the key points raised in this focus group, and omit any references to names.
- Can we have your permission to record?
- [FACILITATOR: Turn on the recorder, repeat the question, and begin recording from this point forward.]
- SECOND, the questionnaire will cover five areas [FACILITATOR: use a flip chart so that it is visually clear for participants. Use a similar as the hand out below]:
    - Identifying children and youth with mental health needs (i.e., screening and assessment).
    - referral to services;
    - service linkage, including responsiveness of other staff/providers in system;
    - service provision; and
    - an open-ended area for your comments.
- For each of these areas, we want to know:
    - what is working well, if anything;
    - what challenges you are experiencing, if any; and
    - what recommendations you have, if any, on how to improve things.
- THIRDLY, we are going to use the 'FISH DIAGRAM' to organize this conversation.
    - We will with the NEWLY DETAINED CASES and then the NON-DETAINED/EXISTING CASE.
    - So, let's begin by giving you 7-10 minutes to get your thoughts on paper (refer to the table).

III. FILLING OUT TABLES [Approximately 10 minutes/Ask them to 'pair up' to get energy flowing. Circulate tables and fish diagram.]

NEWLY DETAINED

	Working Well	Challenges	Recommendations
Identification			
Referral Process			
Service Linkage and Responsiveness			
Service Provision			

NON-DETAINED/EXISTING

	Working Well	Challenges	Recommendations
Identification			
Referral Process			
Service Linkage and Responsiveness			
Service Provision			

IV. FIRST AREA: IDENTIFYING CHILDREN AND YOUTH WITH MENTAL HEALTH NEEDS [approximately 15 minutes.]

A. NEWLY DETAINED CASE

1. What is working well with identifying children and youth in need of mental health services?
   a. Has the process changed from before? If so, how?
      i. Probe: Screening
      ii. Probe: Assessment
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

B. NON-DETAINED/EXISTING CASES

1. What is working well with identifying children and youth in need of mental health services?
   a. Has the process changed from before? If so, how?
      i. Probe: Screening
      ii. Probe: Assessment
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

V. SECOND AREA: REFERRAL PROCESS [approximately 15 minutes.]

A. NEWLY DETAINED

1. What is working well with the referral process for mental health services?
   a. Probe for the following (NOTE: Make sure to cover MAT, WRAP, and Intensive In-Home Services):
      i. Consent process?
      ii. Benefits establishment?
      iii. Referrals to MAT?
      iv. Referrals to Wraparound?
      v. Referrals to Intensive In-Home Services?
2. Are there challenges? If so, which ones?
   a. Probe:
      i. Consent?
      ii. Benefits establishment?
      iii. MAT?
      iv. Wraparound
      v. Intensive In-Home Based Services?
3. What recommendations would you give on how to improve this process or area?

B. NON-DETAINED/EXISTING CASES

1. What is working well with the referral process for mental health services?
   a. Probe for the following (NOTE: Make sure to cover MAT, WRAP, and Intensive In-Home Services):
      i. Consent process?
      ii. Benefits establishment?
      iii. Referrals to MAT?
      iv. Referrals to Wraparound?
      v. Referrals to Intensive In-Home Services?
2. Are there challenges? If so, which ones?
   a. Probe:
      i. Consent?
      ii. Benefits establishment?
      iii. MAT?
      iv. Wraparound?
      v. Intensive In-Home Based Services?
3. What recommendations would you give on how to improve this process or area?

VI. THIRD AREA: LINKAGE TO SERVICES [approximately 15 minutes.]

A. NEWLY DETAINED

1. What is working well with the linkage to services?
   a. How are service providers responding to the linkage?
   b. How much time is it taking to obtain mental health services?
   c. Probe: MAT coordinator?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?
   a. Probe: MAT coordinator?

B. NON-DETAINED/EXISTING CASES

1. What is working well with the linkage to services?
   a. How are service providers responding to the linkage?
   b. How much time is it taking to obtain mental health services?
   c. Probe: Service Linkage Specialist and DMH Co-located?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?
   a. Probe: Service Linkage Specialist and DMH Co-located?

VII. **FOURTH AREA: SERVICE PROVISION** [approximately 15 minutes.]

A. **NEWLY DETAINED/EXISTING CASES**
1. What is working well with the mental health services provided to children?
   a. How do you follow-up with mental health providers?
   b. How do you gauge the quality of the mental health services?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

B. **NON-DETAINED/EXISTING CASES**
1. What is working well with the mental health services provided to children?
   a. How do you follow-up with mental health providers?
   b. How do you gauge the quality of the mental health services?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

VIII.

IX. **FIFTH AREA: ADDITIONAL INFORMATION** [approximately 5-10 minutes.]

A. **TRAINING**
1. What worked well with the training?
2. How can it be enhanced? What would have been helpful?

B. Is there any additional information you would like to mention?

C. Have there been any unintended consequences?

D. Are there any new developments?

E. GLOSSARY OF TERMS

1. **ARA** – DCFS Assistant Regional Administrator
2. **CSAT** – Coordinated Service Action Team
3. **CSWs** – Children's Social Workers
4. **DCFS** – Los Angeles County Department of Children and Family Services
5. **DMH** – Los Angeles Department of Mental Health
6. **DMH Co-located Staff** – DMH Staff that are located in DCFS offices
7. **ER workers** – Emergency Response workers
8. **HIPAA** – Health Insurance Portability and Accountability Act of 1996
9. **HMO Medi-Cal** – Private Healthcare Providers who are contracted by Los Angeles County Medi-Cal.
10. **ISWs** – Intensive Social Workers
11. **MAT** – Multidisciplinary Assessment Team
12. **MAT Coordinator** - Staff members that coordinate the assessment for newly detained children.
13. **MAT Provider** – Contracted agencies that provide assessments and services for children in foster care.
14. **Medi-Cal** – Public Health Insurance program for low-income families.
15. **Medical Hub** – Contracted agencies that provide medical services for foster care children.
16. **MedsLite** – Computer software that allows user to identify the Medi-Cal status of children
17. **MHSA** – Mental Health Services Act
18. **MHST** – Mental Health Screening Tool
19. **RA** – DCFS Regional Administrator
20. **SCSWs** – Supervisor Case Social Worker
21. **SLS** – Service Linkage Specialist
22. **SPA** – Los Angeles County Service Planning Area
23. **TDM** – Team Decision Making
24. **Wraparound** – Los Angeles County initiative since 1998 that integrates multi-agency, community-based planning to support families so that they can safely and competently care for their children.

F. REFERENCE LIST OF FOCUS GROUPS AND INTERVIEWS

1. CSAT Team. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles—Vermont Offices, CA.
2. CSAT Team. Interviewed by James Thing. Focus Group, November 19, 2009. Lancaster, CA.
3. CSAT Team. Interviewed by James Thing. Focus Group, November 17, 2009. Santa Fe Springs, CA.
4. CSAT Team. Interviewed by Samuel Monroy. Focus Group, November 19, 2009. Palmdale, CA.
5. CSAT Team. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.
6. CSAT Team. Interviewed by Taffany Lim. Focus Group, November 17, 2009. Compton, CA.
7. CSAT Team. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles—Waterridge Offices, CA.
8. DCFS Assistant Regional Administrator. Interviewed by Alexis Moreno. Personal Interview, November 19, 2009.Lancaster, CA.
9. DCFS Assistant Regional Administrator. Interviewed by James Thing. Personal Interview, November 19, 2009.Lancaster, CA.
10. DCFS Assistant Regional Administrator. Interviewed by James Thing. Personal Interview, November 17, 2009. Santa Fe Springs, CA.
11. DCFS Assistant Regional Administrator. Interviewed by Rigoberto Rodriguez. Personal Interview, November 17, 2009. Compton, CA.
12. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 19, 2009. Palmdale, CA.
13. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, December 9, 2009. Compton, CA.
14. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles—Vermont Office, CA.
15. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles—Vermont Office, CA.
16. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles – Vermont Office, CA.
17. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Commerce, CA.
18. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Santa Fe Springs, CA.

19. DCFS CSW's. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles–Vermont Office, CA.
20. DCFS CSW's. Interviewed by James Thing. Focus Group, November 19, 2009.Lancaster, CA.
21. DCFS CSW's. Interviewed by James Thing. Focus Group, November 17, 2009. Santa Fe Springs, CA.
22. DCFS CSW's. Interviewed by Rigoberto Rodriguez. Focus Group, November 17, 2009. Compton, CA.
23. DCFS CSW's. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.
24. DCFS CSW's. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles – Waterridge Office, CA.
25. DCFS CSW's. Interviewed by Taffany Lim. Focus Group, November 19, 2009. Palmdale, CA.
26. DCFS Regional Administrator. Interviewed by Alexis Moreno. Personal Interview, November 17, 2009. Los Angeles – Vermont Office, CA.
27. DCFS Regional Administrator. Interviewed by Alexis Moreno. Personal Interview, November 19, 2009.Lancaster,CA.
28. DCFS Regional Administrator. Interviewed by James Thing. Personal Interview, November 17, 2009. Santa Fe Springs, CA.
29. DCFS Regional Administrator. Interviewed by Rigoberto Rodriguez. Personal Interview, November 17, 2009. Compton, CA.
30. DCFS Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, December 17, 2009. Commerce, CA.
31. DCFS Regional Administrator. Interviewed by Taffany Lim. Personal Interview, November 19, 2009. Palmdale, CA.
32. DCFS SCSW's. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles – Vermont Office, CA.
33. DCFS SCSW's. Interviewed by Alexis Moreno. Focus Group, November 19, 2009.Lancaster,CA.
34. DCFS SCSW's. Interviewed by James Thing. Focus Group, November 17, 2009. Santa Fe Springs, CA.
35. DCFS SCSW's. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.
36. DCFS SCSW's. Interviewed by Samuel Monroy. Focus Group, November 19, 2009. Palmdale, CA.
37. DCFS SCSW's. Interviewed by Taffany Lim. Focus Group, November 17, 2009. Compton, CA.

38. DCFS SCSW's. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles – Waterridge Office, CA.

39. DMH Co-located Staff. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles – Vermont Office, CA.

40. DMH Co-located Staff. Interviewed by Samuel Monroy. Focus Group, November 17, 2009. Santa Fe Springs, CA.

41. DMH Co-located Staff. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.

42. DMH Co-located Staff. Interviewed by Taffany Lim. Focus Group, November 17, 2009. Compton, CA.

43. DMH Co-located Staff. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles – Waterridge Office, CA.

44. DMH Co-located Staff. Interviewed by Taffany Lim. Focus Group, November 19, 2009. Palmdale, CA.

45. DMH District Chief SPA 1. Interviewed by Rigoberto Rodriguez. Personal Interview, December 10, 2009.Lancaster, CA.

46. DMH District Chief SPA 6. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles – Vermont Office, CA.

47. DMH District Chief SPA 7. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009, Santa Fe Springs, CA.

48. DMH Program Head SPA 1. Interviewed by Samuel Monroy. Personal Interview, November 19, 2009. Palmdale, CA.

49. DMH Program Head SPA 6. Interviewed by Taffany Lim. Personal Interview, November 18, 2009. Los Angeles – Waterridge Office, CA.

50. DMH Program Head SPA 7. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Santa Fe Springs, CA.

Attachment II

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To:
Fax:

June 15, 2009

Richard Saletta, LCSW
7950 Ridge Road
Newcastle, CA 95658

Dear Mr. Saletta:

Katie A. and the Provision of Wraparound and Related Services

We received a copy of the April 3, 2009 order appointing you Special Master in the Katie A. case. Accordingly, we are writing to provide information which may assist you, the State, and Plaintiffs in upcoming work and to offer the County's ongoing assistance as you deem appropriate and helpful.

As a county that provides wraparound and related services, and as a party to the Katie A. case, we seek to better understand how counties may structure programs to provide these services. To this end, we have enclosed a declaration the County recently filed in this case highlighting some critical operational questions related to county provision of wraparound and like services. An examination of this declaration should assist you and the other parties in this case to better understand the current informational/technical needs of this and other counties.

To further assist, we now propose answers to the questions posed in the earlier declaration. Accompanying each answer below, you and the other parties will find the legal and programmatic basis for each of our propositions.

In the future, we would like to provide additional information about county wraparound programs and to directly participate in discussions around this and related issues. Please do not hesitate to contact me through the information listed above to obtain whatever County assistance you deem appropriate in this regard.

County's Position on Paragraph 5(a)

In a variety of places in DMH Letter No. 08-07 ("DMH Letter"), the State Department of Mental Health ("Department") indicates that activities will be reimbursable if "Medi-Cal criteria are met." In Section II of the DMH Letter, the Department has defined Medi-Cal criteria to include the requirements that (A) the provider meet the standards for

participation, (B) the beneficiary is Medi-Cal eligible without restrictions, (C) the services are medically necessary, (D) the services are within the provider's legally defined scope of practice and (E) the services are appropriately supervised. Presumably, the requirement in the discussion of each service that Medi-Cal criteria must be met means that each of these requirements must be satisfied by the particular services in order for it to be directly paid by Medi-Cal. While it is easy to understand how the requirements at (B), (D) and (E) apply in the context of wraparound services, (but see discussion below on the accuracy of the requirements in (E)), it is less clear how the requirement that the provider meet the standards of participation, and the medical necessity criteria will be applied to individual services, particularly those that that do not strictly have to be done by a licensed person, such as team formation and the actions of the team facilitator.

The County's position with respect to the requirements on the provider in Section II.A, is that, so long as the entity which bills or is reimbursed for the service is duly enrolled in Medi-Cal, the requirement should be deemed to be satisfied. As the State is aware, among the purposes of the specialty mental health waiver was to allow the use of paraprofessional and other personnel in the provision of mental health care, without having to make them fit into the more rigid individual provider categories of classic Medi-Cal. Moreover, the requirements in (D) and (E) assure that the services are rendered by qualified and properly supervised personnel.

With respect to the medical necessity criteria (Section II.C) the County believes that it should be deemed to be satisfied for each of the team planning services outlined in Section V of the DMH Letter, so long as the individual which is the subject of team planning has an included diagnosis and one of the qualifying impairments. The services listed in Section V are necessary elements of the organized and coordinated provision of medically necessary clinical services. Although they themselves may not directly result in a reduction in impairment or deterioration, they are related to and in furtherance of those goals, and therefore should be independently recognized as medically necessary and billable. Indeed, Medi-Cal has long recognized that predicate or administrative actions, like agency staff meeting to discuss who should be a part of the weekly family meetings and assigning responsibility for contacting the proposed attendees to encourage their attendance are necessary components of care and has covered them. Accordingly the Department should affirm that medical necessity for such services exists where the services is related to or in furtherance of medically necessary clinical care.

County's Position on Paragraph 5(b)

We believe that the limitation of covered services to those under the supervision of a Licensed Professionals of the Healing Arts ("LPHA") is unduly restrictive and that

Marriage and Family Therapists ("MFTs"), waivered psychologists, and registered social workers should be able to provide care and supervision. Although the term is not defined in the regulations, an LPHA is generally understood not to include MFTs, registered clinical social workers or waivered psychologists. However, the regulation at 9 Cal. Code Regs. §1840.314(e)(1) which sets forth the qualifications of the individuals who may provide supervision for Medi-Cal covered mental health care, is not so limited. That regulation at subsection (e)(1)(D) specifically permits MFT's to act as care supervisors, and subsection (e)(1)(F) permits waivered/registered professionals to do so, so long as they are supervised in accordance with the laws and regulations governing their status. (See Business and Professions Code § 4996.21 related to supervision of registered clinical social workers) and § 2914(c) (related to psychologists). Allowing such individuals to provide supervision is consistent with the provisions of Welfare and Institutions Code § 5751.2, which expressly permits waivered/registered social workers and psychologists to provide services to Medi-Cal eligible recipients. (See also, DMH Letter 02-09 recognizing that MFTs, registered clinical social workers, and waivered psychologists may provide covered care). Finally, the Agreement between the Department and Mental Health Plans includes all the staff noted in this paragraph as being a part of the "approved category of staff" that may provide direction. Accordingly, the Department should recognize that all of professionals listed in Section 1840.314(e)(1) and similarly in the Agreement (Exhibit A, Attachment 1, Appendix C) can supervise Medi-Cal compensated wraparound services. To accomplish this, the Department should replace the phrase "Licensed Practitioner of the Healing Arts" with, "approved category of staff" which is used in MHP Agreement.

County's Position of Paragraph 5(c)

The only reference to "interagency and intra-agency consultations, coordination, and referrals" made in the DMH Letter is in Section 5.A.2, Team Formation. It is important that the State acknowledge that reimbursable interagency and intra-agency interactions may occur at any time during the Wraparound process. These contacts are important for assuring that mental health services are planned and delivered appropriately given the other conditions affecting the client. Similarly, it is important for other agencies to understand and consider on an ongoing basis the effects of their actions on the child's mental health so that adverse affects can be avoided or mitigated. Therefore all of the time spent on these contacts, throughout the clients' participation in Wraparound should be billable.

The Letter states that the activities conducted or facilitated by a mental health provider would be reimbursable. Because Wraparound is a Team approach, other members of the Wraparound mental health team may also be participants in these inter/intra-agency conferences. Their participation allows them directly to hear and interact from their perspective/role on client issues. This participation is important to the client's mental health treatment planning and execution. Except where the interchange with other

agencies may involve business or eligibility issues; we believe that the time of all mental health team members who have a legitimate reason to participate in an interagency conference should also be Medi-Cal reimbursable.

County's Position on Paragraph 5(d)

The County believes that the time spent by a mental health professional preparing documents (reports, letters, declarations, etc) which are filed with a court or governmental entity having authority over a client should be considered a billable and reimbursable mental health services so long as the documents:

(a) relate to medications for the client's mental health problem, or

(b) address the effect of the client's participation in a placement or program on his or her mental health problem.

For many of the children who participate in a wraparound program, the courts, not their parents, have the authority to make decisions about their medical care. For example, Cal. Welf. & Inst. Code § 369.5 provides that only a juvenile court officer may make decisions regarding the administration of psychotropic medications. Therefore, providing information to the court regarding the need for, or the termination or modification of psychotropic drugs is a necessary step in treating the client. It is analogous to the process of receiving informed consent for the administration of medication, which is expressly recognized in the regulations as a covered component of medication support services. (See 9 Cal. Code Regs. § 1810.225.) Accordingly, the Department should acknowledge that time spent preparing and presenting material to a court regarding mental health-related medications is both billable and reimbursable by Medi-Cal.

Further, it is well established that the mental condition of children with mental health problems are affected by the placements and programs in which the child participates. Environments or programs that are either too restrictive or insufficiently controlled can not only influence a child's behavior, but also impede or enhance the direct therapeutic services that the child is receiving from a mental health professional. For this reason, preparing documentation to a court, or governmental agency or contractor regarding the effect of a particular placement or program on the mental health of a client, as well as making appropriate recommendations, is an important part of assuring the efficacy of other covered mental health services. Because these services are related to assuring the effectiveness of the other clinical services described in the Client Care Coordination Plan, they should not have to be separately listed in the plan to be covered by it. The Department should also recognize these activities as billable and reimbursable mental health services.

County Position on Paragraph 5(e)

The County believes that the Department should issue an Information Notice which formally adopts the EPSDT Chart Documentation Manual, created by California Institute of Mental Health (CiMH), as official guidance on the acceptable standards for documenting EPSDT services, and hold harmless providers who follow such guidelines. However, because the current Manual is occasionally inconsistent with current law or policy, it should be reviewed and revised prior to its adoption. Moreover, the County believes that the Department should work with CiMH and the MHPs periodically to prepare updates which refine existing Manual information and address new programs and services, and formally to adopt such updates when they are issued. The first such update should refine existing Manual language and address documentation standards for wraparound services.

County Position on Paragraph 5(f)

In the DMH Letter, Section V.A.1 recognizes that the gathering of strength-based information, establishing a "strength-based and individualized service plan (mental health client plan)", and "strength focused conversation" are services reimbursable under Medi-Cal. Because this appears to conflict with 9 Cal. Code Regs. §1830.205 which identifies one of the required elements of Medical Necessity as impairments on which interventions are based but makes no mention of strength-based interventions, written clarification of the interplay between these two different treatment philosophies is necessary. Specifically, guidance is needed on the degree to which documentation must link strength-based goals and interventions to the Code required impairment-based goals and interventions. The County believes that the Department should find that it is billable and reimbursable to gather the information necessary to take a strength-based approach when doing an assessment, and that case planning and therapy time which utilizes a strength-based approach, relying on strength-based information, is billable and reimbursable, so long as the effect of such approach is to limit deterioration of the client's mental condition or remediate an impairment.

County Position on Paragraph 5(g)

The County believes that the time spent reviewing information which is provided with a service referral should be considered billable as part of the client assessment. As the DMH Letter recognized in Section III.A, assessment services include "analysis of the beneficiary's clinical history [and] analysis of relevant cultural issues and history." (See also 9 Cal. Code Regs. § 1810.204.) The materials which are provided with the service referral provide significant information about the client's past experiences, including information relating to the past provision on mental health services, prior behaviors, and significant life events. Knowledge of these experiences is critical in determining the etiology of disorders, and in gaining insight into a client's behaviors. Also helpful is

information about successful (as well as unsuccessful) strategies for dealing with the client's problems. All of this information assists the therapist who is conducting an assessment or crafting a Client Care Coordination Plan in preparing a better assessment/client plan, even though the material provided with the referral may be more broad-ranging than the information generally reviewed during an assessment. Accordingly, the Department should recognize that time spent reviewing these materials is essential for formulating a quality plan of care, and acknowledge that it is directly billable to Medi-Cal as part of the assessment service.

County Position on Paragraph 5(h)

To the extent that documentation indicates that a contact included more than just making an appointment, the County believes that the DMH Letter should be construed to allow providers directly to bill for activities such as explaining the Child and Family Team (CFT) process, and inviting significant support persons, such as an aunt, to participate. Often, as my declaration suggests, the participation of such individuals facilitates the client's own participation. In addition, the mental health system expects that service providers will contact and include relevant collaterals to better facilitate the progress or stability of a client. Moreover, recognizing such services as distinctly billable, would be consistent with the definition of covered "collateral" services in the regulation at 9 Cal. Code Regs. § 1810.206. While that definition focuses on achieving goals in the client's care plan, its recognition that contacts with significant support persons can "assist in better utilization of specialty mental health services by the beneficiary" applies equally well to the team formation period. Accordingly, the time communicating with these individuals during the team formation period, as well as during the assessment and plan development period, should be considered directly billable and reimbursable.

County Position on Paragraph 5(i)

The County believes that the discussion in Section V.C of a service plan refers to the Client Plan (in Los Angeles known as the Client Care Coordination Plan) that is required by Section B of Exhibit A, Attachment 1, Appendix C of the MHP Agreement between the County and the Department. The County is pleased that the DMH Letter recognized that covered services may be provided prior to the completion of that Plan as the documented behaviors and/or symptoms of the client often necessitate initiation of direct services before a comprehensive assessment and detailed Client Care Coordination Plan can be developed. The County asks that the Department expressly confirm in an Information Notice or similar document that, at a minimum, the mental health services listed in the second paragraph of V.C. may be reimbursed, when provided before the Client Care Coordination Plan is completed, so long as the services are consistent with the Plan finally developed.

County Position on Paragraphs 5(j&m)

The County's positions on Section III.C. (Personal Care) and Section V.C. (Plan Implementation/Tracking) of the DMH Letter have been grouped together because they require similar actions by the Department. In Section III.C of the DMH Letter, the Department notes that Personal Care Activities are not rehabilitation services and are not Medi-Cal reimbursable. However, Section 1905(a)(24) of the Social Security Act, provides federal Medicaid coverage for personal care services, so long as they are provided outside of a healthcare institution and not rendered by a family member. Personal care services have been incorporated as a benefit into Medi-Cal for categorically needy individuals (see 22 Cal. Code Regs. § 51350). Covered services include bathing, grooming, dressing, feeding and certain domestic services, as well as shopping and meal preparation services. (22 Cal. Code Regs. § 51183.) Therefore, although personal care services are not paid by the MHP, it is incorrect to suggest that they are not covered Medi-Cal services.

Supporting this position, the Department in section V.C indicates that other wraparound activities may be reimbursable under fee-for-service Medi-Cal. The County believes that these additional components of wraparound services should be considered reimbursable under fee-for-service Medi-Cal even though they are related to the client's mental illness: medical transportation, when provided in accordance with the regulation at 22 Cal. Code Regs. § 51323, pharmacy pursuant to 22 Cal. Code Regs. § 51313 et seq. and laboratory services pursuant to 22 Cal. Code Regs. § 51311. The County believes that the Department should issue an Information Notice to provide guidance to providers on how to receive Medi-Cal reimbursement through the regular Medi-Cal fee for service system, when such care is medically necessary.

County's Position on Paragraph 5(k)

The County believes that preparation of a discharge summary by the treating mental health professional within a reasonable time after service termination is always a Medi-Cal billable and reimbursable activity for clients in a wraparound program. To be covered, the discharge plan must be a concise, clinically-oriented description of the client's mental health at the time he or she was released from care, including vulnerabilities, strengths and appropriate follow up activities. Preparation of a discharge summary is required by the MHP Agreement between the Department and the County where "appropriate." (See Exhibit A, Attachment 1, Appendix C, p.41.) Such a document is always appropriate in the wraparound context because it provides the primary means of communicating with future caregivers, and other entities or agencies involved with the client's status on discharge. As the Department recognized in covering transition care, giving the client the tools and information he or she will require

in the future is a necessary component of covered clinical care. For this reason, time spent preparing a qualified discharge summary should be considered a billable mental health service.

County Position on Paragraph 5(l)

The County believes that the limitation on targeted case management services to those which can be specifically linked to the child's mental health related needs in DMH Letter Section III.F is incorrect and inconsistent with State law. A child's access to appropriate housing and nutrition can and does impact a child's mental condition. Nevertheless, the limitation in the letter could be construed to preclude the client from receiving case management help with housing or food, as those needs exist irrespective of mental illness. However, according to the regulation at 22 Cal. Code Regs. § 51351, targeted case management includes assistance with issues related to physical needs, such as food and clothing, and to housing and the physical environment. Limiting persons with mental health problems to a narrower range of targeted case management services undercuts the purpose of the program. The purpose of targeted case management is to provide extra assistance to certain fragile or high risk individuals who need referral and linkage assistance. The scope of the linkage and referrals is supposed to be based on a comprehensive plan created after a thorough assessment of the individual client's overall needs, not just to those needs that relate to the reason for which they have been deemed high risk. For example, persons on probation often receive referrals to health care providers, although health issues have nothing to do with why they are on probation. (See, 22 Cal Code Regs. § 51351(a) and (b).) Accordingly, it is inappropriate automatically to exclude certain types of referrals and linkage services for children with mental health problems simply because they do not directly address the client's mental health needs.

In other communications, the Department has suggested that linkages for housing and food are not covered targeted case management because it is the child's caregiver, and not the child, who is linked. Such a position ignores the obvious fact that decisions about food and housing cannot be made by children or even unemancipated young adults; caregivers are legally responsible for those decisions and the youth lack legal capacity to make them for themselves (e.g. they cannot sign a legally binding rental agreement). Under these circumstances, targeted case management must go through the caregiver if the child is to be served. Therefore, the Department must recognize that targeted case management services which link a covered child's caregiver to housing and food resources which will directly benefit the child are covered and billable Medi-Cal services.

County Position on Paragraph 5(n)

The County believes that Section III.E of the DMH Letter is too limited. It should be

expanded beyond the current provision stating, "Instructions for use as given to the parent by the provider to assist the parent in the appropriate response to the child's questioning of the need to take the medication..." explicitly to include in the scope of covered medication support services, instruction to parents or other caregivers on the proper method of administering mental health related medications and on how to monitor the child for potential side effects, as well as other aspects of the medication. As the Department is aware, parents or caregivers play a more active and important role in the behavior of children than they do with adults. Accordingly, it is critical that they, as well as the child, understand how to administer medication and know what the possible side effects can be. The regulation at 9 Cal. Code Regs. §1810.225 clearly provides both that instruction on the use and risks of the psychotropic medication and contacts with parents or caregivers are covered. The Department therefore must recognize that this regulation, read in light of the needs of children, clearly covers education to parents or other caregivers on all aspects of their child's medications, and is not limited to education on the need for the drugs.

Sincerely,

Olivia Celis, LCSW, MPI.
Deputy Director

Attachment

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March 31, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Marvin J. Southard, D.S.W.
Director of Mental Health

Patricia S. Ploehn, L.C.S.W.
Director of Children and Family Services

SUBJECT: KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003)
- Enhanced Specialized Foster Care Mental Health Services Plan (2005)
- Findings of Fact and Conclusions of Law Order, 2006, issued by Federal District Court Judge Howard Matz
- Health Management Associates Report (2007)
- Katie A. Corrective Action Plan (2007)

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

- Mental health screening and assessment
- Mental health service delivery
- Funding of services
- Training
- Caseload reduction
- Data/tracking of indicators
- Exit criteria and formal monitoring plan

The Strategic Plan also provides that the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS) inform your Board regarding any revisions to the implementation of the Strategic Plan by March 2009, and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents.

The Departments conducted an annual assessment in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement. Previous quarterly reports were submitted on implementation activities on June 30, 2009 and September 30, 2009. This memo serves as the fourth update to our progress in implementing the Strategic Plan.

Implementation Support Activities

A number of activities were conducted during this period to support the implementation of the Strategic Plan.

- DCFS Director Trish Ploehn, and DMH Director Dr. Marvin Southard, issued a joint memorandum regarding the role of the DMH co-located staff in responding to consultation requests from DCFS Children's Social Workers (CSWs).

- DCFS Medical Director Dr. Charles Sophy, DCFS Katie A. Division Chief Adrienne Olson, DMH Deputy Director Olivia Celis, and DMH Child Welfare District Chief Greg Lecklitner have completed Katie A. Strategic Plan presentations in all 18 DCFS Regional Offices, Adoptions, and Medical Case Management Services. These presentations provided an overview of the Strategic Plan's basic elements as well as a forum to engage in dialogue with Regional Office staff regarding implementation issues. Presentations were also made to Dependency Court Officers, Family Preservation, County Counsels, Los Angeles Dependency Lawyers, Children's Mental Health Providers, and Medical Hub personnel.

- On January 22, Chief Executive Office (CEO), DCFS, DMH, and County Counsel representatives met with the Katie A. State Negotiations Team and Special

Master Rick Saletta, to discuss the Katie A. implementation efforts in Los Angeles County.

- CEO, DCFS, and DMH continue to participate in a variety of Katie A. related meetings, including monthly Executive Leadership Team meetings, bi-monthly Project Leadership Team meetings, bi-weekly Specialized Foster Care Managers meetings, and monthly Katie A. Operation's meetings. Departmental managers and Katie A. Advisory Panel members are also provided with monthly Katie A. updates.

- Monthly progress reports have been prepared for your Board providing updates on the rollout of the screening, assessment, and treatment elements of the Strategic Plan, including Referral Tracking System (RTS) Summary Data Sheets.

- DCFS continues to develop and maintain the Katie A. Website.

- DMH and DCFS implementation efforts related to the Strategic Plan continue across 18 major activity domains and the progress of these workgroups is being documented in individual Project Data Sheets.

- DCFS has now hired 79 of the 81 positions allocated in the Strategic Plan and DMH has hired 29 of the 42 positions allocated.

- Department representatives from DCFS, DMH, CEO, and County Counsel participated in a two and one half day meeting in December with the Katie A. Advisory Panel, discussing training activities, data collection, and Treatment Foster Care. A panel comprised of Coordinated Services Action Team (CSAT) team members from Service Planning Area (SPA) 7 provided the Panel with an overview of initial and ongoing implementation. The Panel members had the opportunity to inquire about their "on the ground" experience.

- DMH District Chief Greg Lecklitner continues to participate as a member of the Katie A. State Negotiations team, working toward a settlement of the Katie A. State case.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan, are described below.

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health services. Nine Project Teams comprise the Screening and Assessment component of the Plan as follows: 1) Medical Hubs; 2) Coordinated Services Action Team (CSAT);

3) Multidisciplinary Assessment Team (MAT); 4) Referral Tracking System (RTS); 5) Consent/Release of Information; 6) Benefits Establishment; 7) D-rate; 8) Team Decision-Making (TDM), Resource Management Process (RMP); and 9) Specialized Foster Care (SFC). Significant progress continues to be made by each of these project teams.

Medical Hubs: From July 2009 through December 2009, 77% of newly detained children received an initial medical examination at a Hub. During this quarter, the DCFS Training Section provided training to all of the Medical Hub personnel on the completion of the Mental Health Screening Tool (MHST). The goal of the training was to provide assistance to the Hub staff in completing the mental health screens properly and also to assist in standardization of the forms across all of the Hubs. Further, the Child Welfare Health Services Section provided presentations to DCFS Regional Office staff on the utilization of Medical Hubs Procedural Guide, including completion of the revised Hub Referral Form and on completion of the revised Notice to Caregivers Form. The purpose was to ensure CSWs and Supervising Children's Social Worker (SCSWs) are accessing the Hubs appropriately.

Moreover, in January 2010, the utilization of the Hub Policy was revised to reflect the Ninth Circuit Court of Appeals ruling as it pertains to forensic evaluations. Additionally, the agreement for a web-based patient information system, E-mHub, is targeted to be approved by your Board on March 30, 2010. E-mHub will allow the Hub referral information to be submitted electronically from DCFS to the Hubs and will also allow results to be submitted back to DCFS in a PDF file for cutting and pasting into the Child Welfare Services/Case Management System (CWS/CMS). Finally, a comprehensive plan, which included the allocation of out-stationed CSWs at each of the six Department of Health Services Medical Hubs, Public Health Nurses (PHNs), and DMH co-located staff at DCFS' after-hours Emergency Response Command Post (ERCP), was developed to ensure that 100% of newly detained children are seen at the Hubs and to address other aspects of quality assurance tasks. However, due to the County's current funding constraints, this plan is being revisited to determine how resources can be effectively maximized.

CSAT: On May 1, 2009, CSAT was implemented in SPA 7 (the Belvedere and Santa Fe Springs offices). On August 1, 2009, CSAT was implemented in SPA 6 (the Compton, Wateridge and Vermont Corridor offices). SPA 1 (Lancaster and Palmdale offices) implemented CSAT in September 2009. All Phase I offices have implemented CSAT and the hiring of 20 additional staff to support the CSAT process in the Phase II offices has been completed.

Following the full implementation of CSAT in the Phase I offices, your Board commissioned a first year Implementation Evaluation. The results of this study completed in January 2010, in conjunction with input from your Board and a review of 51 DCFS children's cases resulted in the redesign of the screening tool, policies/procedures, the tracking system, and training curriculum. The proposed

redesign delayed the rollout of CSAT to DCFS offices not yet trained. A new CSAT rollout schedule is expected to be completed by June 2010. Those offices already trained and implementing CSAT (in SPAs 1, 6, 7, El Monte, and Pomona) will be retrained and will implement the new procedures first, followed by the remaining offices.

From the time that CSAT was implemented in Phase I offices to March 10, 2010, 9,440 children with open DCFS cases received mental health screens, meeting a 96% compliance rate of children requiring a screen. Of those children, 94% who received a positive screen were referred for mental health assessments, and of those deemed to be in need of mental health services, 91% were linked to mental health services.

According to the Katie A. first year Implementation Evaluation, comprised of information collected across 27 focus groups in all seven Phase I offices, CSAT is viewed as a structure that has brought greater order, efficiency and accountability to assessment and linkage services. The Implementation Evaluation reports, "CSWs underscored that the CSAT brings together staff with special skills, knowledge, resources and networks to ensure that children who are newly detained, non-detained or with existing cases are appropriately and efficiently assessed and linked to services."

Now that Service Linkage Specialists (SLS) in the Phase I offices have ensured the mental health screening, referral, and service linkage of children in existing cases, the SLS are able to devote more time to developing community based resources that can serve Medi-Cal ineligible children. The SLS in all offices are partnering with Department of Public Social Services (DPSS) co-located Linkages staff to help more families get enrolled in Medi-Cal and access adult services available through DPSS. The SLS are cross-trained to perform the DCFS MAT Coordinator function to process MAT referrals in the event the MAT Coordinator is out of the office.

In order to further refine the organized, timely, and comprehensive delivery of services across the spectrum of current programs, the SLS manager is now working with managers from D-rate, Wraparound, Family Preservation, and Treatment Foster Care to create a more inclusive referral process that will expedite linkage from the CSAT to these programs when appropriate. SLS and MAT Coordinators will identify Wraparound eligible children on new cases in order to offer earlier, more intensive interventions with the goal of reducing the child's length of stay in care.

MAT: Countywide MAT implementation was effective as of October 2009. From October 2009 to January 2010, there were 1,446 MAT referrals made and 1,177 MAT assessments completed.

In January 2010, seven DCFS offices referred 90% - 100% of all MAT eligible children. Five offices referred between 70% - 80% of all MAT eligible children and the remaining five were still ramping up and below 70%. Currently, seven of the eight SPAs are referring over 70% of eligible children. SPA 1 continues to have provider capacity issues. As of January 2010, SPA 1 referred 26% of all eligible MAT children.

DCFS MAT Coordinators are working with DMH and the MAT agencies to identify more children who are eligible for Wraparound and D-rate earlier. MAT staff (DMH, DCFS and MAT agencies) meet at the SPA level on a regular basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Operations Workgroup composed primarily of experienced MAT providers, DCFS and DMH managers is working to standardize and refine the MAT process, improve the quality of MAT reports and overcome barriers that prevent MAT agencies from completing the Summary of Findings Report (SOF) in time to be considered by the court at Dispositional Hearings. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders of the date to the agencies. DCFS has also worked with the Dependency Court to create a one-page template that can be submitted to the Court in the event that a MAT assessment will not be completed in time for the Dispositional Hearing. This one-page template provides a summary of the MAT agency's recommendations that the court can use so they can make orders regarding the child's case plan.

DMH has issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol and MAT checklist. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT Program. DMH is also convening a MAT Best Practices Workgroup to further refine the assessment process and ensure the MAT SOF Report is completed in line with recommendations made by the Children's Services Investigation Unit.

RTS: The Referral Tracking System is currently operational on the DCFS side in a total of seven DCFS regional offices in SPAs 1, 6, and 7. As of March 10, 2010, 9,440 children received mental health screens since implementation on May 1, 2009, and were tracked through the RTS for referral and mental health service linkage. DCFS and DMH continue to meet on a bi-monthly basis to further refine the accuracy of the RTS as lessons are learned. Beginning May 30, 2009, detailed summary data reports have been produced and submitted to your Board on a monthly basis. Additional information related to the RTS is provided in the "Data/Tracking of Indicators" section below.

Consent/Release of Information: DCFS and DMH, in concert with their respective County Counsels, have developed procedures and forms to provide for the consent for mental health services for referred children, as well as the authorization to release protected health information for purposes of the child's care and coordination of services. Recommendations from children's and parent's attorney groups have been received and incorporated in the forms and finalization is imminent. Meetings with the Children's Law Center, the Los Angeles Dependency Lawyers, Judicial Officers, County Counsel, DMH and DCFS management continue to take place in an effort to finalize language and protocols related to the securing of consent and the authorization to release information.

DMH is currently finalizing a protocol that will allow for an exception to the DMH policy regarding the use of protected health information in e-mails. This protocol will allow

DMH co-located staff and DCFS CSWs to communicate client information via the internet.

DMH is also finalizing a practice guideline related to consultation requests involving adult mental health information. The guidelines will allow DMH co-located staff to share adult caretaker mental health information in certain circumstances through the formation of a multidisciplinary team.

Benefits Establishment: A process for benefits determination for all new and existing cases has been established in support of CSAT implementation.

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the MEDSLITE benefits establishment system. MEDSLITE is a condensed version of the Medical Eligibility Determination System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT Coordinators that serves as an instructional guide for the use of MEDSLITE, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

CSAT staff engage in a close collaboration with the DPSS co-located Linkages staff to help more children who live with relatives and in their parents' home to become Medi-Cal eligible, receive income support, job training, substance abuse treatment and domestic violence interventions for which they qualify. DCFS managers work closely with DMH Revenue Management staff to better understand and resolve eligibility concerns expressed by DMH providers.

D-rate: In addition to the D-rate program's continued work to review and ensure mental health services for at least 90% of D-rate children, the duties of the DCFS D-rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning, and service coordination for other high-need children. Over 2,400 reports have been submitted to Court in the last year on the perceived effects of psychotropic medications on children under Juvenile Court supervision.

DCFS and DMH have identified the MAT SOF document as a potential alternate means by which children on new cases can be assessed for the D-rate. This innovation could reduce some costs for the County and increase the number of children receiving an increased intensive level of care with more well-trained caregivers earlier in their case. Additionally, all newly certified D-rate cases are now being reviewed by DREs for referral to Wraparound, in recognition of the fact that most new D-rate children meet the criteria for Wraparound and could benefit from the intensive intervention provided.

TDM/RMP: Eight TDM facilitators were hired in the last quarter, now totaling 84 DCFS facilitators available at DCFS to coordinate TDMs and RMPs. In December 2008, DCFS mandated replacement TDMs, otherwise known as RMPs, for all youth entering or exiting a Residential Care Level (RCL) 6-14 placement. Each regional office developed and implemented a "firewall" to ensure all youth entering, or exiting a RCL had a RMP. The initial results from the RMP analysis show that the process is having a positive impact on the timely connection to services and the number of subsequent replacements. RMPs continue to show promise in securing more community-based placements for youth through Wraparound or other services. RMP utilization increases every month and the general feedback from the offices is positive.

Specialized Foster Care (SFC): DMH now has a total of 316 items dedicated to support the work of Katie A., including 65 Countywide administration items and 251 service area items. At present, 288 of these items are filled. DMH currently has 178 staff co-located in 18 DCFS Regional Offices, providing SFC services. SFC continues to provide Countywide support for the implementation of the various Katie A. initiatives; including Wraparound and MAT. The SFC staff that are co-located in the DCFS Regional Offices fulfill functions for data management, training, and the development of practice guidelines. Moreover, all SFC co-located staff have been trained in Trauma-Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, such as abuse, neglect, and domestic and community violence.

Mental Health Service Delivery

On May 1, 2009, the County began implementation of Tier II Wraparound, an expansion of the existing Wraparound program.

Currently, approximately 1,000 children are enrolled in Tier I Wraparound, and an additional 561 children are enrolled in Tier II Wraparound. There is a target of 75 additional Wraparound enrollments each month for Tier II.

In order to increase Wraparound enrollments, the Departments recently issued a policy that will allow Tier I Wraparound providers the opportunity to self-select up to 10 children to enroll in the Wraparound Program. The 10-child self-referral pilot is underway and showing promise. The County and the providers are now looking at implementing a similar pilot for Tier II. Additionally, the County is exploring the option of eliminating the rotation process for referrals. This will allow for providers to self-refer more youth appropriate for Wraparound and will allow CSWs to refer directly to providers they trust.

In October 2009, the Wraparound Program received the Grand Eagle award, as one of the County's top three programs, from the County of Los Angeles Quality and Productivity Commission.

Another intensive mental health service program, originally discussed in the Katie A. CAP, is the County's Intensive Treatment Foster Care (ITFC) Program. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 treatment foster care beds by January 2008. A new target of 300 beds by December 2012 was established as the target. The ITFC Program has been making slow but steady progress in bed development, contract approvals, program implementation, placement, referral and matching procedures, and agency collaboration. The program remains viable and extremely valuable to those youth placed in an ITFC home.

The ITFC Program met the November 30, 2009 projected target of 25 developed beds. The next target is 44 beds by May 31, 2010. The program is currently on track to meet this goal in that there are 33 certified beds and 15 homes pending certification. It is expected that these additional 15 homes will be certified on or before May 2010, bringing the total up to 48 beds and slightly above the projected target of 44.

The likelihood of continued success was strengthened when your Board approved the execution of ITFC contracts to nine Foster Family Agencies (FFAs) on November 17, 2009. "Start Work" letters were sent out in January 2010 to these nine agencies. Your Board also delegated DCFS the authority to execute ITFC contracts with other suitable FFAs. Four such contracts are now pending final approval by the CEO. Meeting the final goal of 300 ITFC beds by December 2012 is therefore, expected.

The ITFC agencies are presently hiring and training program staff, recruiting and training foster parents, and participating actively in monthly implementation meetings organized by the DCFS and DMH Treatment Foster Care (TFC) Managers. DMH has arranged for the required training of the Multidimensional Treatment Foster Care (MTFC) and ITFC Program staff for each FFA.

Another improvement over the last six months has been the increased collaboration among various DCFS and DMH divisions involved in the ITFC Program, resulting in an increased flow of referrals of children and the streamlining of the Inter-agency Placement Review Team (IPRT) protocols for identifying, selecting, and matching these emotionally and behaviorally disturbed children for ITFC foster homes. As of March 9, 2010, there are 24 children placed in an ITFC home and six are undergoing the matching process.

In an effort to maximize available service dollars, DMH Director Dr. Marvin Southard, issued a memo encouraging providers to use their various Katie A. related funding allocations (i.e., Wraparound, MAT, Intensive In-Home, and Basic Mental Health Services) flexibly in providing services to DCFS children.

DMH children's mental health providers have begun a curtailment and transformation process in order to respond to the current State budget crisis. DMH providers will be transforming their current mental health services into various evidence-based mental

health practices funded through the Mental Health Services Act Prevention and Early Intervention initiative. Examples of these evidence-based approaches include Trauma-Focused Cognitive Behavior Therapy, Seeking Safety, Triple P Positive Parenting Program, Child-Parent Psychotherapy, Cognitive Behavior Intervention for Children in Schools, Cognitive Behavioral Therapy for Major Depression, and the Managing and Adapting Practice (MAP) system.

DMH has recently contracted with the University of California Los Angeles to collaborate on a MacArthur Foundation Grant with Professor Bruce Chorpita to train approximately 100 clinicians in the use of a set of evidence-based practices and to compare the outcomes of this approach with usual mental health services. This project may have significant implications for improving the quality of children's mental health services in the County.

Funding of Services/Legislative Activities

All three Departments are closely monitoring expenditures this fiscal year and anticipate some savings. Approximately $16 million in fiscal year (FY) savings from 2008-09 are in a Provisional Financial Uses (PFU). CEO recommends using these savings to offset enhanced fiscal commitments in FY 2010-11 in support of the incremental rollout of the Katie A. Strategic Plan. As previously discussed in the last Quarterly Report and in the Katie A. Strategic Plan first year Implementation Evaluation, a number of important initiatives identified after the development of the Katie A. Strategic Plan are being funded within the current year Katie A. allocation. Currently, there is approximately $10.7 million in savings for FY 2009-10.

DMH continues to participate weekly in negotiations, led by a court-appointed Special Master, with the State and Plaintiff attorneys regarding the State portion of the Katie A. lawsuit. As previously discussed in the first year Implementation Evaluation, the County's continued participation in the Court mediated negotiations between the Plaintiffs and State remains the County's most viable opportunity to maximize revenue reimbursement to the County. The last meeting on this topic for this phase of the discussions concluded on March 18, 2010. The Special Master is preparing a report to the Court to be submitted later this month discussing next steps to reach a resolution in this case.

The County met with the State and Special Master on January 21, 2010 to discuss the legal, fiscal, regulatory, and programmatic obstacles impeding implementation of the Katie A. Strategic Plan. We subsequently met with the Special Master on March 22, 2010 to discuss the implementation obstacles in greater detail along with the anticipated timelines for submitting the Special Master's Report to Court. It is hoped that whatever agreements are established will result in improved claiming opportunities for Katie A. related mental health services, particularly through Wraparound related service activities. Concurrently to participating in the State Katie A. negotiated discussions, the County has been following up with the State to obtain the State Plan Amendment

language concerning the Schedule of Maximum Allowances for the provision of mental health services. The State has not been forthcoming with this language, but we will continue to follow-up and share any new information as it becomes available.

Training

DMH and DCFS have worked closely together to develop and implement the necessary training components relating to the Strategic Plan, including:

- Curriculum for the Enhanced Skill-Based Training for CSWs/SCSWs has been developed jointly with the Inter-University Training Consortium. A pilot for CSWs and SCSWs is being scheduled for April 2010.

- Continued CSAT training to support the rollout of the CSAT, including a variety of training on new policies and practice guidelines associated with activities as mental health screening, obtaining mental health consent and authorization to release information, and referral of screened cases to the DMH co-located staff. CSAT training has been completed for staff in SPAs 1, 6, 7, El Monte, and Pomona regional offices; DCFS ERCP; DMH Family Preservation; D-rate; DCFS Specialized Programs; and Medical Hubs. Two follow-up trainings have been delivered to the Wateridge office in February 2010. CSAT training is also scheduled for the DCFS Sexual Abuse Team in late March 2010.

- Wraparound training was provided for DCFS SCSWs and CSWs, as well as DMH co-located staff, to promote the identification and referral of children appropriate for this service in accordance with Katie A. Plan components.

- Training across all DCFS offices continues to support targeted strategies for outcome achievement (safety, permanence, and well-being) to facilitate safe caseload reduction including TDM training, Emergency Response Policy/Practice, and Intentional Visitation.

- Coaching and mentoring curricula for all line DCFS SCSWs is under development. Casey Family Programs and California State University Long Beach have been meeting to create a coaching model for Emergency Response (ER) SCSWs, which will then be expanded to all Family Maintenance and Permanency Planning SCSWs.

- DMH provided a series of trainings designed to improve provider skill levels and capacity in the assessment and treatment of infants and toddlers and children with co-occurring developmental disabilities. DMH has also prioritized training in reflective supervision to enhance coaching and mentoring skills for DMH directly-operated and contract providers.

Development of a joint DMH/DCFS Core Practice Model (CPM) continues as input from a variety of stakeholders as well as the review of 13 other States' Core Practice Models is being considered. The CPM will serve to align the two Departments and the continuum of providers in the identification of children's needs and strengths. The CPM will incorporate teaming across traditional role boundaries to support the provision of services to meet the needs of children and families, and in implementing coaching/mentoring models to support practice improvement consistent with the elements of the Qualitative Service Review (QSR).

In March 2010, DMH contracted with the California Institute for Mental Health (CIMH) to assist the Department in developing the core mental health competencies associated with the CPM and initiating a training program for DMH co-located staff and contract providers. The training will also include skill building in providing intensive home based services and trauma-informed practice. The CIMH contract will also provide for training the ITFC providers and Full Service Partnership providers in Trauma-Focused Cognitive Behavior Therapy.

Caseload Reduction

The Strategic Plan outlines a number of initiatives to be undertaken by DCFS in support of the Department's need to reduce foster care as well as the caseload sizes of CSWs in order to accomplish the Strategic Plan goals. We are pleased to note that the progress reported in our earlier quarterly updates continues.

The Department's total out-of-home caseload has been reduced from 15,748 as of May 2009 to 15,680 as of January 2010. Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanence and well-being (including early mental health intervention) for the children in our care.

As for individual CSW caseload sizes the number of children in generic caseloads have been reduced from an average of 26 children per social worker to 22.48 children per social worker as of January 2010, while the Emergency Response (ER) caseload has been reduced from an average of 24 children per social worker to an annual average of 19.25 children per social worker as of January 2010. The decrease in caseload sizes are attributed to a number of factors, but one key is that 434 new CSWs were hired from June 2008 through July 2009, exceeding the goal of 160 new hires described in the Strategic Plan. In addition, as of January 2010, the CSW vacancy rate is only at 3%.

Data/Tracking of Indicators

DCFS has developed an interim RTS to track the systematic implementation of mental health screenings per SPA and DCFS offices according to the three tracks for screening: newly detained cases, newly-opened non-detained cases, and existing cases. DMH has designed a parallel system on their side to track the referral of cases

for mental health services. The DMH RTS is still being refined, but is being piloted in the Phase I CSAT offices. Significant refinements to the DCFS RTS were recently completed that included correcting the case opening date to reflect the removal or disposition date resulting in a far more accurate representation of daily practice. This interim system is part of a larger automated effort to comprehensively store and track, without violating State Automated Child Welfare Information System regulations, child welfare and mental health service information regarding mental health screenings, referral to DMH for positive screens, and receipt of mental health service. The DCFS RTS is in the early design phase and greater functionality and expanded access for DMH clinicians will be sought over the next several months.

The Departments recently received approval from County Counsel on a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The DMH Chief Information Office Bureau is currently developing the project plan for this solution and has completed the interim solution that will be used to automate the collection of information to be used for the Katie A. monthly reports to your Board.

DMH has purchased the SAS Dataflux system which will be used for future matching of DMH and DCFS client data. This software is now undergoing testing and adjustment. In the interim, DMH and DCFS continue to perform monthly client matches with the assistance of the Internal Services Department and this data is used to update the DMH Cognos Cube.

DMH is producing monthly reports that compare provider allocations related to Katie A. with their usage of these dollars. These reports are shared with DMH contract managers and are used to consult with providers to maximize their financial allocations.

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the successful adoption by the BOS and the Federal District Court of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators and a passing score on the QSR.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by your Board, Panel, and Plaintiffs' attorneys, and, as previously noted, the Strategic Plan was approved by the Federal District Court on July 22, 2009. This notes the first time since the inception of the lawsuit that a County developed Plan for Katie A. has been approved by the Court, which is a significant achievement in itself for the County and identifies a practical timeline with objective criteria for exiting the lawsuit.

DMH, DCFS, and CEO in conjunction with the Panel, County Counsel, and Plaintiffs' Attorneys, continue to work on finalizing a discrete set of data that will be tracked as either formal exit criteria or contextual information as one of three prongs, described above for monitoring compliance with the Settlement Agreement. A tentative

agreement has been reached with the Panel on the Safety and Permanency indicators to be tracked, in addition to the targets that are to be maintained for a duration of time to achieve compliance with this aspect of the exit criteria. A call with the Panel to finalize the details of the reporting timelines for tracking these indicators will be discussed on March 26, 2010. The goal is to finalize agreement around this set of indicators before launching the discussions on the mental health screening, assessment, and service delivery exit indicators which will commence directly after the finalization of the Safety and Permanency indicators.

The QSR process is planned to take place in three phases. Phase I calls for the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan. These activities are expected to be completed by July 2010.

Phase II, to be completed between September 2010 and December 2012, commences the administration of the QSR across the 18 DCFS Regional Offices; while Phase III, to be completed by December 2013, consists of any follow up reviews that might be necessary to achieve passing scores.

DCFS has hired a Children's Services Administrator II to head a new Quality Improvement Section that will have lead responsibility for implementation of the QSR process. DMH has now hired a Mental Health Counselor R.N. who will serve as the liaison from DMH in this effort. DCFS and DMH staff made a joint visit to Utah in November 2009, to participate in their QSR process as a preview of the activities that will need to take place in Los Angeles County. Now that staff is in place, the QSR protocol will be detailed in the coming months including the proposed sample size, percent standard for achieving a passing score, and criteria for exiting the review process.

On January 12, 2010, the QSR contract was executed between Los Angeles County and Human Systems and Outcomes (HSO), Inc. HSO is a for-profit management consulting and performance measurement organization that holds the copyright on the QSR Tool. Between January 19 and January 21, 2010, a series of Leadership Orientation Meetings (with Executive Leaders, Regional Program Managers, Practice Champions and Information Technology Participants) were conducted and facilitated by Dr. Ray Foster, Director of HSO to help leaders gain an understanding of how QSR works, how it links to the joint DCFS/DMH CPM and how to use QSR results to stimulate and support service system change. Between February 23 and February 25 2010, Dr. Foster lead an on-site Design Team process, consisting of a well formed working group representing stakeholders in practice development, local practice partners, and end-users of the QSR results to guide the design and use of the protocol and processes being developed. Key child and family status indicators and system performance indicators have been identified for development to comprise our Los Angeles County customized QSR protocol. Between March and May of 2010, a

technical review of the draft protocol will be refined and prepared for pilot testing. Advance preparations are also underway to identify the initial sequence of offices to undergo the first reviews. In June 2010, selected staff will be identified and trained in the new QSR protocol, and it is projected that the first "pilot" review test will be conducted.

Summary

The implementation of the Katie A. Strategic Plan is being fully executed by the Departments, with support from the CEO, and progress has been made toward achievement of the Settlement Agreement objectives. The Strategic Plan has been organized into 18 project teams, each having sponsors, managers, team members and Project Data Sheets that are updated quarterly to summarize the objectives, outcomes, deliverables, resources, dependencies, risks, and benefits. The Departments' steadfast oversight and collaboration facilitated through the Katie A. Executive Leadership, the Departmental Leadership, and the Project Leadership Teams, are evident and rapidly moving the County toward resolution of its obligation. Quarterly reports describing the ongoing progress will continue to be provided to your Board along with the monthly reports on the implementation of CSAT and the RTS.

During the last six months, the County has continued to demonstrate significant progress toward meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Among the most significant accomplishments are:

- The mental health screening of over 9,400 DCFS children since the initial implementation in SPA 7 and the provision of mental health services to those with identified mental health needs.

- Targeted initiatives to support inter-departmental collaboration and information sharing.

- Continued hiring and training of DMH and DCFS staff to fill allocated positions.

- Completion of the first year Implementation Evaluation.

- Ramping up of the Tier II Wraparound Program, now serving over 550 children.

- Continued implementation of the MAT program through development of provider capacity and quality improvement efforts.

- Further refinements to the DCFS RTS and initiation of the DMH RTS.

- Meeting with the Katie A. State Negotiations Team and Special Master.

- Ongoing large-scale training efforts related to the Strategic Plan, including CSAT, Wraparound, MAT, and the CPM.

- Further reductions in the caseloads of DCFS CSWs.

- Initiation of activities to prepare for the implementation of the QSR, including contracting with the developer of the tool, meetings with DMH and DCFS executive teams, and the work of the Design Team.

As a result of these ongoing efforts, the County continues to enhance the positive working relationship with the Katie A. Advisory Panel and the Federal District Court overseeing the Settlement Agreement.

Future quarterly reports will be provided in June, September, and December of this year.

Please let us know if you have any questions regarding the information contained in this report, or your staff may contact Olivia Celis-Karim, DMH Deputy Director, at (213) 738-2417 or ocelis@dmh.lacounty.gov .

MJS:PSP:OC:GL:eg

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

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WILLIAM T FUJIOKA
Chief Executive Officer

July 1, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003);
- Enhanced Specialized Foster Care Mental Health Services Plan (2005);
- Findings of Fact and Conclusions of Law Order (2006), issued by Federal District Court Judge Howard Matz;
- Health Management Associates Report (2007); and
- Katie A. Corrective Action Plan (2007).

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services	4. Training
5. Caseload Reduction	6. Data/Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

The Strategic Plan also provides that the Departments of Children and Family Services (DCFS) and Mental Health (DMH) inform your Board regarding any revisions to the implementation of the Strategic Plan and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents. The Departments conducted an annual assessment in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement.

Previous quarterly reports were submitted on implementation activities in June 2009, September 2009, and March 2010. This memo serves as the fourth update to our progress in implementing the Strategic Plan.

Implementation Support Activities

- Greg Lecklitner, DMH District Chief, continues to participate as a member of the Katie A. State Negotiations Team, which is working toward a settlement of the Katie A. State Case;

- The DCFS Bureau of the Medical Director is hosting a series of four "D-Rate Town Hall" meetings throughout the County and has invited all foster parents, relative caregivers, and adoptive parents to attend. The goal of these meetings is to have a dialogue with caregivers about the D-Rate Program and to understand the difficulties faced when meeting the needs of children for whom they are responsible;

- DCFS, Department of Health Services, DMH, and the Chief Executive Office (CEO) managers have met with five of the seven Medical Hubs: High Desert Health System Multi-Service Ambulatory Care Center, Harbor-UCLA Medical Center Hub, Children's Hospital Los Angeles, LAC+USC Medical Center Hub, and Martin Luther King Jr. Multi-Service Ambulatory Care Center. The LAC+USC East San Gabriel Valley Satellite Hub visit is scheduled for August 25, 2010, and the Olive View-UCLA Medical Center Hub visit is scheduled for August 31, 2010. The Hub meetings are held to increase collaboration, ensure a strong understanding of Hub operations and to plan for improved access and service delivery;

- DCFS continues to develop and maintain the Katie A. Website;

- DCFS has now hired 80 of the 81 positions allocated in the Strategic Plan, and DMH has hired 36 of the 42 positions allocated; and

- Department representatives participated in a two and a half day meeting with the Katie A. Advisory Panel in May 2010 to discuss the Core Practice Model (CPM), Qualitative Services Review (QSR), Multidisciplinary Assessment Team (MAT) case review and overall Strategic Plan Implementation issues.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan are described below.

OBJECTIVE NO. 1

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health service needs. Below are the Screening and Assessment components of the Plan:

- *Medical Hubs* • *Coordinated Services Action Team (CSAT)* • *MAT* • *Referral Tracking System (RTS)* • *Consent/Release of Information* • *Benefits Establishment* • *D-rate* • *Team Decision-Making (TDM)* • *Resource Management Process (RMP)* • *Specialized Foster Care (SFC)*

Medical Hubs:

From July 2009 through February 2010, 82 percent of newly detained children received an initial medical examination at a Hub.

DCFS continues to improve child health outcomes for DCFS children by ensuring that 100 percent of the priority populations of DCFS children are referred to and served by the Medical Hubs. In June 2010, the DCFS Medical Director issued a memorandum to all DCFS staff defining the priority populations as:

- Newly detained children placed in out-of-home care;
- Children who are in need of a forensic evaluation to determine abuse and/or neglect; and
- Children with special health care issues that need a follow-up exam, i.e., diabetes, hemophilia, developmental delay, etc.

As a result, the DCFS' utilization of Medical Hubs' Procedural Guide will also be revised to align the priority populations with the memorandum.

In addition, the County has taken steps to improve the continuity of care from the Medical Hubs and has begun the development and implementation of an Enterprise Medical Hub (E-mHUB) system. The E-mHUB system will record the healthcare information of all DCFS children and allow information sharing between all Medical Hub sites and DCFS.

The E-mHUB system agreement was approved by your Board on March 30, 2010, and the sole source agreement with Sega Technology Inc. was executed in May 2010. An E-mHUB Project Workgroup has convened to ensure that the vendor meets its deliverables.

CSAT Redesign Roll-Out and Training Schedule:

On May 1, 2009, CSAT was implemented in Service Planning Area (SPA) 7 (Belvedere and Santa Fe Springs). On August 1, 2009, CSAT was implemented in SPA 6 (Compton, Wateridge and Vermont Corridor). SPA 1 (Lancaster and Palmdale) implemented CSAT in September 2009, and SPA 3 (El Monte and Pomona) implemented CSAT on April 1, 2010.

In response to the January 19, 2010 motion from Supervisors Molina and Knabe, DCFS and DMH staff reviewed a sample of 51 children's cases from the DCFS Santa Fe Springs Regional Office for mental health screening, referral, and start of mental health services. The cases were randomly selected from newly detained children (25 cases) and newly opened non-detained children (26 cases).

The case review revealed several areas of needed improvement to bring the Departments into full compliance with best practice child welfare mental health standards. The screening tool will be revised to improve its sensitivity in identifying children with mental health needs and to triage children according to acute, urgent, or routine mental health needs. The revised Child Welfare Mental Health Screening Tool (MHST) was specifically designed to be administered by DCFS Children's Social Workers (CSWs).

The new MHST was piloted in the following CSAT implemented offices: SPA 7 (Belvedere and Santa Fe Springs); SPA 6 (Compton); SPA 1 (Lancaster and Palmdale); and SPA 3 (El Monte) from May 11, 2010 to May 28, 2010. The primary differences between the previous and new MHST includes the indication of acuity, the elimination of severe symptoms as a requirement to meet criteria for a positive mental health screen and the addition of parenting abilities for children age 0-5 years. The acuity measure reflects the child's need for a mental health assessment as acute, urgent, or routine.

The pilot sample consisted of 17 completed MHSTs. Pilot results revealed that 76 percent of the CSWs felt that the new MHST was easier to complete and 77 percent were able to complete the new MHST within 0–15 minutes. Upon further modification based on the

feedback received, the new MHST will be instituted following CSAT Training according to the CSAT implementation schedule in all DCFS Offices.

DCFS policy will be amended to require Emergency Response (ER) CSWs to complete the MHST for any child in conjunction with the promotion of a DCFS case and to contact the DMH Psychiatric Mobile Response Team (PMRT) when children appear to be in immediate need of mental health services. Co-located DMH staff will primarily respond when children present with urgent or routine mental health needs.

Policy and procedures are in place to serve children with acute and urgent mental health needs, moreover DMH and DCFS are working to enhance urgent psychiatric care and crisis stabilization for DCFS involved children. DMH is exploring future collaboration with two urgent care centers already in existence through Exodus (LAC+USC and Culver City) as an additional mental health resource for DCFS children with acute or urgent mental health needs.

DCFS CSWs currently "informally" re-screen children at each home visit, but "formal" re-screenings on an annual basis are needed to systematically ensure children with mental health needs are identified on an on-going basis. Policy will be amended to require CSWs to complete annual re-screenings of children who screened negative at case opening and are not receiving mental health services.

The Medical Hubs will continue to complete mental health screenings using the established process and original MHST as a back-up or safeguard to screenings being completed by DCFS CSWs. After Countywide implementation of CSAT and the MHST, the Departments will revisit the Medical Hub's screening process to determine if the revised MHST will be implemented at the Medical Hubs and/or what other procedural changes may be needed to increase efficiencies and quality of service.

In total, a redesign of the MHST, DCFS, and DMH policies and procedures, tracking system, and training curriculum are currently underway. The redesign has delayed the roll out of CSAT to DCFS Offices not yet trained. Those offices already trained and implementing CSAT (SPAs 1, 6, 7, El Monte, and Pomona) will be retrained and will implement the new procedures first, followed by the remaining offices.

The training roll out per office is depicted in Table 1.

Table 1: CSAT Redesign Training and Roll-Out Schedule

DCFS Office	Training Month	Trial Month	CSAT Roll Out	Referral Tracking System Report to Board
Belvedere, SFS	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct .2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster	Sept. – Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Pomona, El Monte, Pasadena, Covina Annex (Asian Pacific & American Indian Units Only)	Oct. – Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
Glendora	Nov. – Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011
Metro North	Dec. – Jan. 2011	Feb. 2011	Mar. 2011	May 2011
West Los Angeles (and Deaf Services)	Jan. – Feb. 2011	Mar. 2011	Apr. 2011	June 2011
Lakewood, Torrance	Feb. – Mar. 2011	Apr. 2011	May 2011	July 2011
San Fernando Valley, Santa Clarita	Mar. – Apr. 2011	May 2011	June 2011	Aug. 2011
Medical Case Mgmt. Services	May 2011	June 2011	July 2011	Sep. 2011
Emergency Response Command Post	May 2011	June 2011	July 2011	Sep. 2011

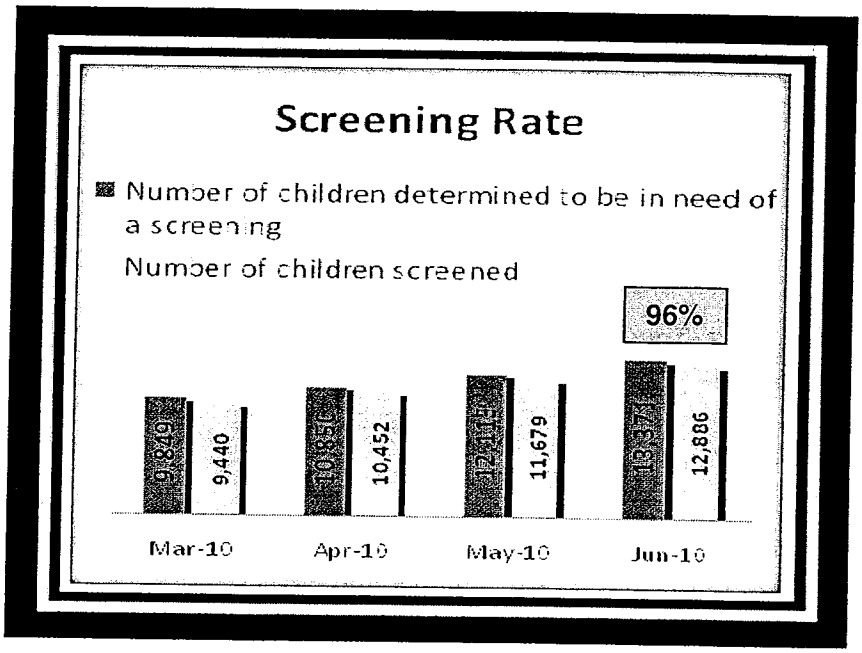
CSAT SUCCESS STORY

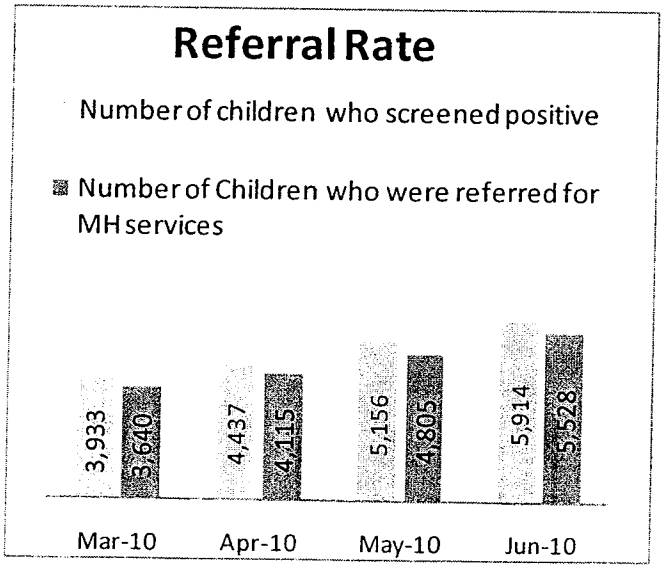
A 21-year-old youth's transitional plan to live in a Regional Center Board and Care facility following DCFS supervision was delayed after he was denied Social Security Income (SSI) benefits due to a missed appointment with the Social Security Administration (SSA). Additionally, his Medi-Cal benefits were interrupted, impacting his ability to pay for his medication. The Service Linkage Specialist (SLS) worked closely with the CSW, caregiver, SSA, and Regional Center to resolve his SSI status and reactivate his Medi-Cal. The youth's SSI was approved, Medi-Cal was reactivated, and his medication costs were

covered. At the transition conference, it was determined that the Regional Center would assume funding for residential placement upon receipt of a court order for the youth's emancipation and successful transition from DCFS jurisdiction.

RTS

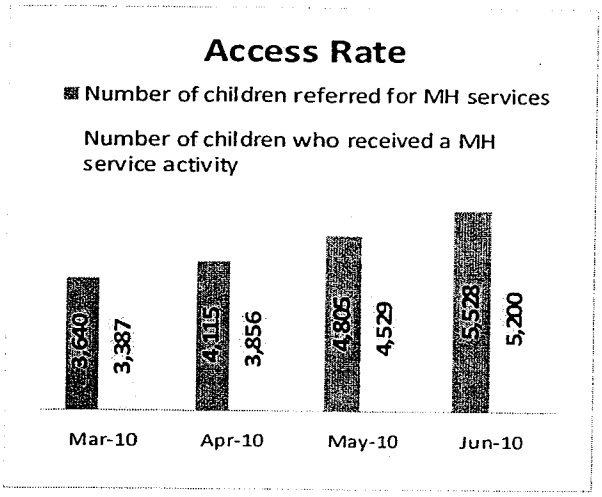
The RTS is currently operational in DCFS and DMH in a total of nine DCFS Regional Offices in SPAs 1, 3, 6, and 7. As of the June 30, 2010 CSAT/RTS Monthly Report, 12,886 children received mental health screens since implementation on May 1, 2009 and were tracked through the RTS for referral and mental health service linkage.





- As of the June 30, 2010 Monthly Report, out of the **5,914** children who screened positive, **5,528** children were referred for mental health services at a **96 percent** referral rate.

- As of the June 30, 2010 Monthly Report, out of **5,528** children referred for mental health services, **5,200** children received a mental health service activity within 30 days of the referral at a **94 percent** access rate.



MAT

In April 2010, 83 percent of all MAT eligible newly detained children Countywide were referred to MAT. From October 2009 to April 2010, there were 2,559 MAT referrals and 2,057 MAT assessments completed.

In April 2010, 12 DCFS Offices referred 90 percent to 100 percent of all MAT eligible children. Six offices referred between 70 percent and 80 percent of all MAT eligible children – only one office is currently below 70 percent. Six of the eight SPAs are referring over 70 percent of eligible children. SPA 1 referral rates lag behind due to provider capacity issues. The rate of MAT compliance is depicted in Table 2.

Table 2: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	48	29	60%
SPA 2	65	61	94%
SPA 3	92	84	91%
SPA 4	32	29	91%
SPA 5	7	7	100%
SPA 6	87	58	67%
SPA 7	78	65	83%

SPA 8	65	62	95%
Total number of DCFS MAT referrals:	**474**	**395**	**83%**

*Cumulative includes all April 2010 MAT referrals within each DCFS office and SPA.

MAT staff (DMH, DCFS, and MAT agencies) meet at the SPA level on a monthly basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Operations Workgroup, composed primarily of experienced MAT providers, DCFS and DMH managers, is working to standardize and streamline the MAT process, improve the quality of MAT reports and overcome barriers that prevent MAT agencies from completing the Summary of Findings (SOF) Report in time to be considered by the Court for the dispositional hearing. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders of the date to the agencies. DCFS MAT Coordinators work closely with the Dependency Court attorneys to ensure that children have the appropriate consents to receive needed services.

DMH and DCFS have issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol, MAT checklist, and MAT CSW Interview Survey. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT program. DMH and DCFS are also convening a MAT Best Practices Workgroup to further refine the assessment process and ensure the MAT SOF Report is completed in line with recommendations made by the Children's Services Investigation Unit.

To date, DMH MAT Coordinators have completed a total of 154 MAT Quality Improvement (QI) checklists. The checklists represent their findings based upon a review of the MAT SOF. QI checklists were received from the eight SPAs. The MAT QI checklist calls for yes/no responses within eight domains. The results of the MAT QI checklists are summarized below.

Results within MAT QI domains:

1. 85 percent of the SOFs reviewed showed that the assessors demonstrated reasonable efforts to engage all the stakeholders in multidisciplinary activities to support the information gathering/assessment process;

2. 83 percent showed the SOF report adequately assessed all of the MAT domains of functioning;

3. 87 percent showed the SOF reports contained adequate description and information;

4. 88 percent showed the SOF final report was completed within 45 days;

5. 95 percent showed the strengths of the children, family, and other caregivers were adequately described;

6. 90 percent showed the needs of the children, family, and other caregivers were adequately described;

7. 92 percent showed the recommendations made in the report were consistent with the assessment information; and

8. 96 percent showed the recommendations were specific enough to be efficiently implemented.

Overall, 90 percent of the individual domain ratings were positive.

This was a high-needs sexual abuse case that required a Resource Utilization Management (RUM) assessment and linkage to Wraparound. The MAT Coordinator worked with the RUM Worker to expedite the RUM referral without having to hold an additional meeting with the family. The MAT Coordinator suggested that the RUM Worker complete the Child and Adolescent Needs and Strengths (CANS) tool with information from the MAT SOF Report and any additional interviews. The MAT Coordinator also helped secure the children's acceptance to the Wraparound program.

Consent/Release of Information

DCFS and DMH, with their respective County Counsels, have developed procedures and forms to provide for the consent of mental health services for referred children, as well as the authorization to release protected health information for purposes of children's care and coordination of services. Recommendations from children's and parents' attorney groups were incorporated and the pending revisions have been approved by the Children's Law Center, the Los Angeles Dependency Lawyers, County Counsel, DMH, and DCFS management. In addition, all parties approved standardized language that CSWs can insert into court reports to obtain consent from the courts when they are unable to secure parents' signatures. The DCFS training section will train service providers and staff from both Departments on the revised consent and release of information forms and provide guidance as to which information can and cannot be shared.

DCFS has also consulted with Regional Center in an effort to ensure that DCFS policies appropriately address the needs of all children. As a result, DCFS has learned that current policies on developmental needs and services will need to be revisited. Regional Center

management has agreed to attend the Consent Project Team meetings to provide consultation on appropriate requirements and procedures.

The DMH Practice Guidelines related to consultation requests involving adult mental health information is completed and being reviewed by County Counsel prior to being vetted by both Departments. The Guidelines include information on the formation of multidisciplinary teams that may allow DMH co-located staff and service providers to share adult caregiver mental health information to assist DCFS in providing protection to children and support to families. DCFS has agreed to create a comparable policy to clarify which situations merit consultation with DMH and what information can be shared within this context.

Benefits Establishment

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the MEDSLITE benefits establishment system. MEDSLITE is a condensed version of the Medical Eligibility Determination System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT Coordinators that serves as an instructional guide for the use of MEDSLITE, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

Although the MEDSLITE system is helpful in providing a child's Medi-Cal eligibility status, "at a glance" one of the limitations to the system is that it does not provide the issue date of a child's Medi-Cal card, needed most by DMH providers for mental health service billing.

Also, in some cases, Medi-Cal benefits have been erroneously discontinued when children are replaced. In an effort to avoid such problems, this group is currently targeting the systemic problems that result in lapses in children's Medi-Cal benefits to help ensure ongoing and timely health services.

D-rate

In addition to the D-rate Program's continued work to review and ensure mental health services for at least 81 percent of D-rate children, the duties of the DCFS D-rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning, special placement requests and approvals, and service coordination for other high-need children.

Over 3,000 Pyschotropic Medication Authorization (PMA) Reports have been submitted to Court by DREs in the last 15 months on the perceived effects of psychotropic medications on children under Juvenile Court supervision. Additionally, the D-Rate Program received an

assignment to ensure that all youth in Foster Family Agencies that are taking psychotropic medication were contacted for follow-up from February through April 2010. DREs reviewed 626 cases of children identified by CWS/CMS as having current psychotropic medication. Of the 626 children, only 380 were taking psychotropic medication. Of these children, 91 percent were taking medication as prescribed with current PMAs on file, and eight percent (29 children) were taking medication with no current PMA on file.

TDM/RMP

DCFS has completed 4,427 TDMs from January through March 2010. This was an increase of 208 TDMs from the previous three months (October through December 2009). Additionally, DCFS completed a total of 449 RMPs with 67 percent of youth entering a group home, 69 percent of youth replaced and 59 percent of youth exiting a group home. This was an increase of 83 RMPs from the previous three months (October through December 2009).

Finally, DCFS continues efforts to phase in TDMs at the Emergency Response Command Post (ERCP). There were a total of 29 TDMs completed. Preliminary data reflects positive outcomes: 18 (62 percent) of the ERCP TDMs resulted in children remaining home with their respective caregivers; and 21 (72 percent) of the ERCP TDMs convened had the participation of community-based agency partners.

SFC

The DMH Child Welfare Division/DMH co-located staff responds to requests for consultation from DCFS CSWs, provides referral and linkages to community-based mental health providers, and participates in the CSAT process in those offices where CSAT has rolled out. Moreover, all SFC co-located staffs (a total of 70 clinicians) have been trained in Trauma-Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, and provide this treatment on a case-by-case basis. Currently, DMH has 178 co-located staff in 18 DCFS Regional Offices.

OBJECTIVE NO. 2

Mental Health Service Delivery

DMH has been working with its provider community to improve capacity and utilization of mental health services, particularly among those providers, now totaling 64, who have received a Katie A. related contract (including Wraparound, MAT, Treatment Foster Care, Comprehensive Children's Services Program, and Basic Mental Health Services). In total, these contracts provide for over $97 million of targeted mental health services for DCFS children. In addition to these targeted contracts, DMH children's providers also use their general service contracts to provide needed services to DCFS children. We anticipate that

the total Early Periodic Screening Diagnosis and Treatment (EPSDT) expenditures related to the provision of mental health services for DCFS children will reach approximately $300 million for Fiscal Year (FY) 2009–10.

A memorandum was issued by DMH Director, Marvin J. Southard, encouraging these providers to maximize their contract utilization on behalf of DCFS involved children. To support this effort, DMH has encouraged a flexible approach to the utilization of Katie A. related allocations, consistent with good mental health practice, in providing mental health services to DCFS involved children and has made the necessary adjustments in the DMH Integrated System to track these expenditures. Furthermore, DMH District Chiefs are provided with monthly reports which track Katie A. related allocations and expenditures among the DMH contract providers.

Wraparound

On May 1, 2009, the County began implementation of Tier II Wraparound, an expansion of the existing Wraparound Program.

As of April 30, 2010, 1,048 children are enrolled out of a maximum total of 1,400 available slots in Tier I Wraparound, and for the first time ever since the roll out of Tier II, 887 children are enrolled in Tier II Wraparound as of May 2010, exceeding the cumulative target by 12 slots.

In March 2010, the Departments issued a directive that allowed Tier I Wraparound providers the opportunity to self-refer up to ten children to enroll in Wraparound. Based on the positive results in May, the ten child self-referral pilot was moved to a permanent option and it included Tier II. As mentioned in the last update, the County explored the option of eliminating the rotation process to providers for referrals, however, it was decided that the rotation will remain in place after meeting with the providers. A more recent effort to increase Wraparound referrals is a "rule in" for Wraparound whenever there are mental health issues present. Wraparound and the CSAT have partnered to ensure all youth are considered for Wraparound.

Treatment Foster Care (TFC)

The County's TFC Program is another intensive mental health service program, originally discussed in the Katie A. CAP. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 TFC beds by January 2008. A proposal to develop 300 beds by December 2012 was established as the new target. The TFC Program, which includes a planned 220 beds of Intensive Treatment Foster Care (ITFC) and 80 beds of Multi-dimensional Treatment Foster Care (MTFC), continues to make slow but steady progress in bed development, program implementation, placement, and interagency collaboration.

The primary challenge with TFC remains with bed development. On June 15, 2010, the TFC program had a total of 43 certified TFC foster homes; one less than the projected target of 44 beds. This growth is directly related to the nine agencies moving forward in the implementation of their TFC teams. Each has hired and trained all team members, including the evidence-based training for their clinicians through DMH in Trauma Focused-Cognitive Behavioral Therapy and/or Multi-dimensional Treatment Foster Care. Three additional Foster Family Agencies are expected to reach full implementation of their TFC teams by July 2010.

As of 6/15/2010

Agency	Total # of Placed Children	Total Certified Homes	Certified Homes Vacancies	**Certified Homes on Hold	Upcoming Beds (cert. incomplete)
Intensive Treatment Foster Care (ITFC)					
Five Acres	10*	11*	1	2	7
ChildNet	5	7	0	2	2
Olive Crest	1	2	0	1	0
Penny Lane	0	0	0	0	6
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	0	0	0	0
The Village	1	4	2	1	4
CII	0	0	0	0	6
David and Margaret	0	0	0	0	4
SUB TOTAL	17	24	3	6	29
Multi-dimensional Treatment Foster Care					
CII	3	7	2	2	0
Penny Lane	1	7	4	2	9
ChildNet	0	5	5	0	0
David and Margaret	0	0	0	0	2
SUB TOTAL	4	19	11	4	11
GRAND TOTAL	**21**	**43**	**14**	**10**	**40**

* Three children placed in one ITFC home

**Per Agency request

DMH has added capacity within the MTFC program to serve children as young as six years old. DMH has also expanded MTFC capacity from two SPAs to five SPAs. With the TFC teams in place, the agencies are now tackling the time-consuming task of recruiting, certifying and training TFC foster parents. TFC program staff is assisting in recruitment with more proactive outreach to existing licensed foster parents that might be interested in working with the TFC target population.

DMH has contracted with UCLA to partner on a three-year research project which will examine the use of various evidence-based practices for children and adolescents as compared to usual or conventional treatment approaches. This project, known as ChildSTEPs, will provide substantial training, consultation and technical assistance, and tracking of outcomes for those mental health providers participating in the study and will inform future planning of children's mental health services.

DMH has also begun a large scale transformation of mental health services related to the Mental Health Services Act Prevention and Early Intervention Program. As part of this initiative, children's mental health providers are being trained in a variety of evidence-based practices, including Trauma-Focused Cognitive Behavior Therapy, Triple P (Positive Parenting Program), Child Parent Psychotherapy, Depression Treatment Quality Improvement (DTQI), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Managing and Adapting Practice (MAP), and Seeking Safety.

OBJECTIVE NO. 3

Funding of Services/Legislative Activities

All three Departments are closely monitoring expenditures this fiscal year and similar to previous years, there will be savings, primarily stemming from vacant Wraparound slots. Currently, we anticipate approximately $20 million in fiscal year savings from 2009-10. CEO recommends, as we did with the FY 2008-09 savings, rolling the FY 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 in support of the incremental roll out of the Strategic Plan.

Since the beginning of this year, Tier II Wraparound enrollments have increased by 52 percent. Moreover, for the first time since the roll out of the Tier II slots in May 2009, Tier II enrollments for May 2010 exceeded the monthly target. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings will decline in the out years.

The Special Master in the State portion of the Katie A. case filed a report with the Court on May 28, 2010. The Court has accepted the Special Master's Report and is extending his appointment through November 2010 in order to clarify positions, narrow differences, and reach agreements between the State and Plaintiffs. Notably, much of the County's service

delivery philosophy and selection of intensive home-based mental services detailed in the Strategic Plan has been incorporated in the Special Master's Report. Weekly negotiations between the parties will resume in July, and DMH will continue to represent the County in these discussions. As previously discussed, the County's continued participation in the Court mediated negotiations between the Plaintiffs and State remains the County's most viable opportunity to maximize revenue reimbursement to the County.

OBJECTIVE NO. 4

Training

A draft of the joint DMH/DCFS CPM was presented to the Katie A. Panel on May 11, 2010. It included input from 85 focus groups, community stakeholders, as well as the wisdom of 13 other States' Core Practice Models. The CPM will serve to align the two Departments and the continuum of providers in the identification of children's needs and strengths. The CPM will incorporate teaming across traditional role boundaries to support the provision of services to meet the needs of children and families, and in implementing coaching/mentoring models to support practice improvement consistent with the elements of the QSR.

The California Institute of Mental Health (CIMH) also made a presentation to the Panel regarding the assistance they are providing to DMH in developing the core mental health competencies associated with the CPM and initiating a training program for DMH co-located staff and contract providers. The training will also include skill building in providing intensive home-based services and trauma-informed practice. The CIMH contract will also provide training for the ITFC providers and Full Service Partnership providers in Trauma-Focused Cognitive Behavior Therapy.

DMH and DCFS have worked closely together to develop and implement the necessary training components relating to the Strategic Plan, including:

- All DCFS Line Supervisors have been asked to attend one of the four one-day Supervising CSW conferences. They will be introduced to a Coaching and Mentoring training as part of the shared CPM to enhance family engagement and practice to promote good outcomes for children and families. The first Supervisor Conference was held June 15, 2010;

- All DCFS Offices (with the exception of Lakewood, Santa Fe Springs, and Belvedere) have received Wraparound training. The remaining offices will be trained by September 2010; and

- The Enhanced Skill-Based Training Pilot begins in July 2010. This training consists of three two-day modules. Model 1: "A Culturally Strength-Based Approach" will be

held July 13–14, 2010. Model 2: "Effective Engaging" will be held on July 21–22, 2010. Model 3: "Teaming with Families" will be held July 28–29, 2010.

OBJECTIVE NO. 5

Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,748 (May 2009) to 15,680 (January 2010). As of May 2010, the total out-of-home caseload has decreased to 15,405.

Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency and well-being.

As of January 2010, individual CSW generic caseload sizes have been reduced from an average of 26 to 22.48. A slight increase in this average in May 2010 brought the average caseload to 24.94 children per social worker.

As of January 2010, the ER caseload was reduced from an average of 24 to 19.25. This service component also experienced a slight increase through May 2010, bringing the current referral average to 19.72. The increased trend in caseload and referral averages is due to the increased number of ERCP referrals received within the past six months, increased workload tied to heightened safety measures in emergency response activities and investigations, and the need to address an increasing backlog of emergency response investigations.

OBJECTIVE NO. 6

Data and Tracking of Indicators

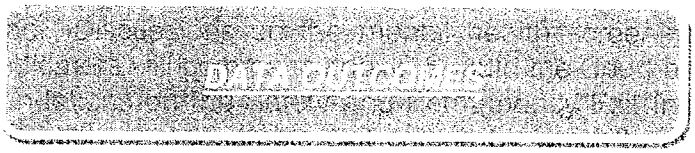
The Departments, with approval from County Counsel, implemented a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The SAS Dataflux system is being used for matching DMH and DCFS client data. The software has undergone extensive parallel testing, with the assistance of the Internal Services Department, to improve the validity of client matches. It is anticipated that the SAS Dataflux system will be in full production by August 2010, whereby matches can be conducted more frequently, potentially on a monthly or weekly basis.

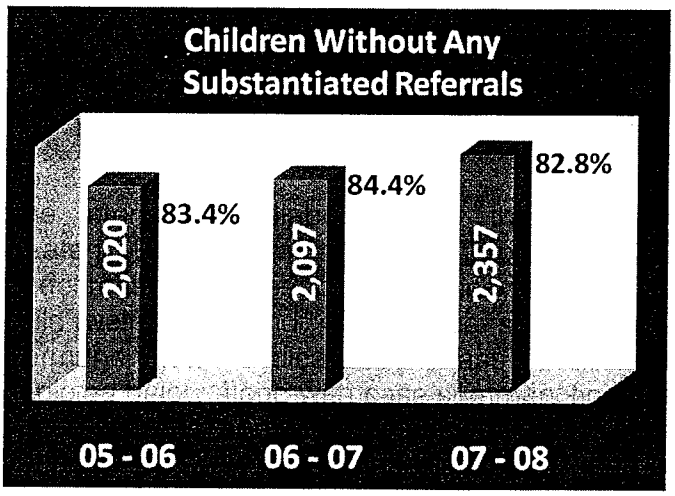
As previously discussed in the last quarterly report, the County and the Panel tentatively reached agreement on a set of Safety and Permanency Exit Indicators to track and targets to be maintained for duration of time to achieve compliance with this aspect of the exit criteria. At the end of March 2010, the agreement was solidified and the Katie A. Panel

agreed to attach the Safety and Permanency Exit Indicators to their next report in July 2010 for Court consideration. Discussions on the mental health screening, assessment, and service delivery exit indicators will commence next. Should the Court agree with the County and Panel's recommendations on the Safety and Permanency Exit Indicators and targets, the first step in identification of measurable exit criteria by which to evaluate the County's progress in complying with the Katie A. lawsuit would be accomplished.

SAFETY	PERMANENCY/REDUCED OUT-OF-HOME CARE	WELL-BEING	SELF-SUFFICIENCY

The intensified collaboration of the departments to advance the objectives of the Strategic Plan is simultaneously impacting DCFS key goals to: 1) improve child safety; 2) decrease timelines to permanency and reduce reliance on out-of-home care; 3) improve child well-being; and 4) enhance self-sufficiency. A sampling of Katie A. Safety and Permanency Exit Indicators for class members (those receiving mental health services) are depicted below along with case summary findings from a quality assurance review of mental health records and a data indicator demonstrating improvement in safe and affordable housing upon service termination for those enrolled in the Independent Living Program.





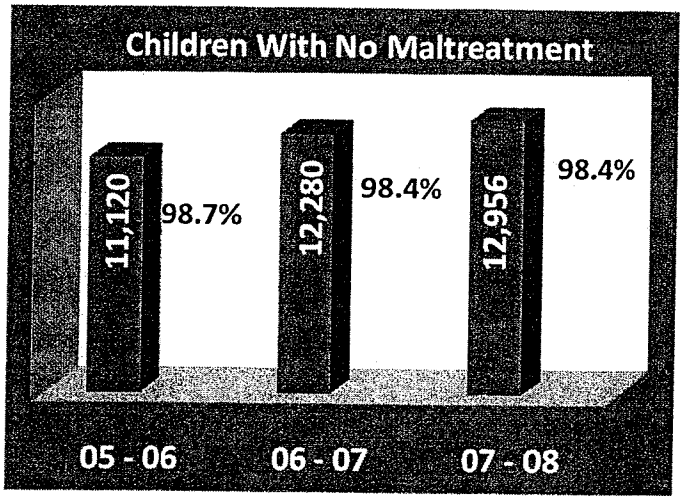
Safety Indicator 1:

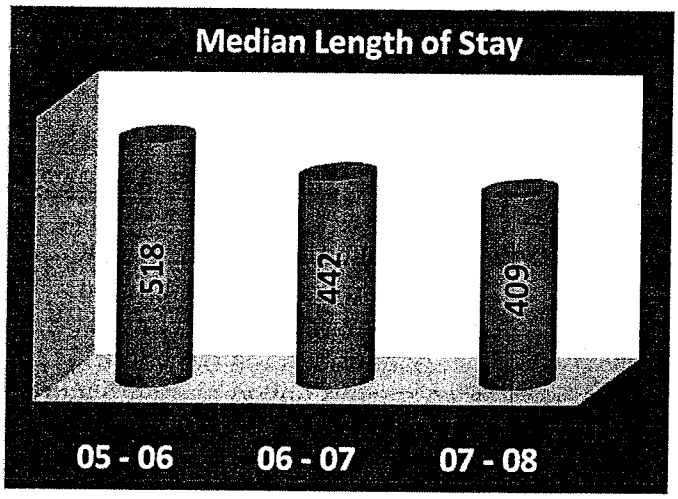
Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

This indicator has remained fairly stable over the last few years at roughly 84 percent and demonstrates that the majority of children are remaining safely at home.

Safety Indicator 2:

Of all children served in foster care in the fiscal year receiving mental health services, how many did not experience maltreatment by their foster care providers? Again, this indicator has remained stable at 98 percent indicating that the majority of children in foster home settings experienced no substantiated foster parent maltreatment.



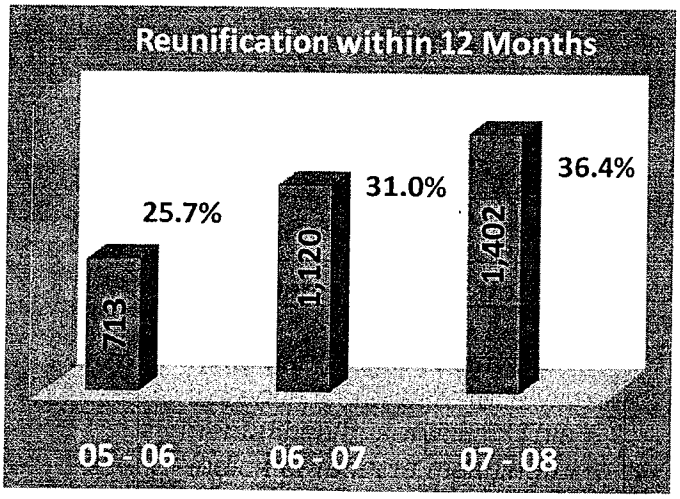


Permanency Indicator 1:

Median length of stay for children in foster care receiving mental health services. This indicator reflects meaningful improvement – a 21 percent decline – in median days in foster care from FY 2005-06 to FY 2007-08.

Permanency Indicator 2:

Reunification within 12 months for children receiving mental health services. Dramatic improvements in reunification are evident – a 97 percent increase from FY 2005-06 to FY 2007-08.



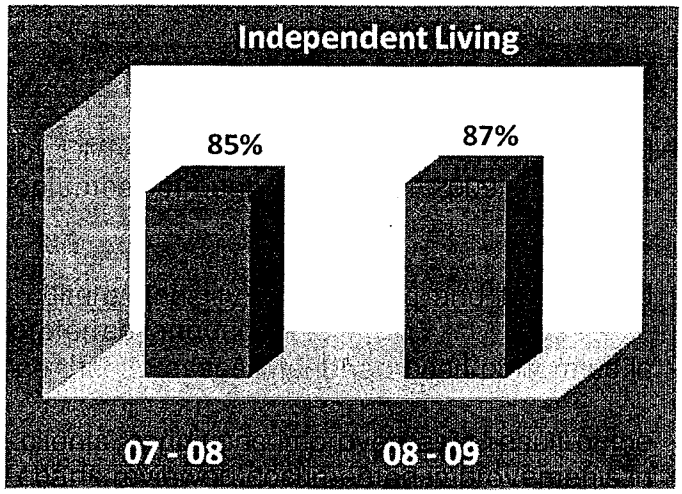
(Well-Being) Quality of Mental Health Services

A quality assurance chart review conducted by DMH for 43 DCFS children referred to and receiving mental health services between September through December 2009 in SPAs 1 and 6, revealed the following:

- All 43 charts reviewed identified the culture/ethnicity of the child and family and provided services in the child/family's preferred language;
- All 43 charts reviewed showed evidence that an assessment had been performed in a timely manner;
- 39 of the 43 charts indicated that the clients' conditions improved as a result of the mental health services received. The charts reviewed documented improvements in children's coping skills, school performance, and relationships with peers and family members; and
- 34 of the 43 charts indicated that children received mental health services in a home or school setting.

Self Sufficiency:

Percent of foster youth who received Independent Living Program (ILP) services and are living in safe and affordable housing upon service termination at age 21. The majority of youth participating in ILP do transition to safe and affordable housing upon service termination. The rate slightly increased in FY 2008-09.



OBJECTIVE NO. 7

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the successful adoption by your Board and the Federal District Court of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators and a passing score on the QSR.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by your Board, Panel, and Plaintiffs' attorneys, and, as previously noted, the Strategic Plan was approved by the Federal District Court on July 22, 2009. This notes the first time since the inception of the lawsuit that a County developed plan for Katie A. has been approved by the Court, which is a significant achievement in itself for the County and identifies a practical timeline with objective criteria for exiting the lawsuit.

The QSR process will take place in three phases. Phase I calls for the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan. These activities are expected to be completed by July 2010.

Phase II, to be completed between September 2010 and December 2012, commences the administration of the QSR across the 18 DCFS Regional Offices; while Phase III, to be completed by December 2013, consists of any follow-up reviews that may be necessary to achieve passing scores.

Key child and family status and system performance indicators have been identified to comprise our Los Angeles County customized QSR protocol. Between March and May of 2010, a technical review of the draft protocol had been conducted and a refined pilot review version of the Protocol was finalized for pilot testing. Advance preparations have also been underway to identify the initial sequence of offices to undergo the first round of reviews.

DCFS and DMH staff have been identified to receive QSR protocol training on June 24-25, 2010. The first "pilot" review test is scheduled June 28 – July 2, 2010 in the DCFS-Belvedere Office.

Summary Highlights

During the last three months, the County has continued to demonstrate significant progress toward meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Significant highlights from the last report include:

- Revision of the MHST screening tool and DCFS/DMH related policies and procedures. A detailed timeline was established for the revised roll out of the MHST training across the 18 DCFS Regional Offices, beginning with the Belvedere and Santa Fe Springs Offices in August 2010. Katie A. management from DCFS, DMH, and CEO met with the Service Employees International Union Local 721 in May 2010 to discuss the revisions to the MHST. In June, a follow-up letter was submitted to the union indicating that since no feedback had been received on the forms that implementation of the revised MHST would go forward as discussed;

- A draft QSR instrument/protocol and scoring criteria have been developed collaboratively with the Katie A. Panel and the instrument will be piloted June 28 - July 1, 2010 in the DCFS Belvedere office. This is a momentous achievement for the County and an incremental step forward in fulfilling the exit criteria from the Katie A. lawsuit;

- Agreement with the Katie A. Panel on a set of Safety and Permanency Exit Indicators and targets to serve as exit criteria;

- Development of the Core Practice Model and Enhanced Skill-Based Training Curriculum; and

- Infusion of the children's mental health system with Mental Health Services Act Prevention and Early Intervention funding and transformation of a portion of general EPSDT allocations to promote the development of a set of evidence-based mental health practices.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Acting Deputy Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:KH:LB
AM:hn

c: Executive Office, Board of Supervisors
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Department of Children and Family Services
Department of Mental Health

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WILLIAM T FUJIOKA
Chief Executive Officer

September 30, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003);
- Enhanced Specialized Foster Care Mental Health Services Plan (2005);
- Findings of Fact and Conclusions of Law Order (2006), issued by Federal District Court Judge Howard Matz;
- Health Management Associates Report (2007); and
- Katie A. Corrective Action Plan (2007).

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

The Strategic Plan also provides that the Departments of Children and Family Services (DCFS) and Mental Health (DMH) inform your Board regarding any revisions to the implementation of the Strategic Plan and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents.

Previous quarterly reports were submitted on implementation activities in June 2009, September 2009, March 2010 and July 2010. This memo serves as the fifth update to our progress in implementing the Strategic Plan.

Implementation Support Activities

- Greg Lecklitner, DMH District Chief, continues to participate as a member of the Katie A. State Negotiations Team, which is working toward a settlement of the Katie A. State Case.

- The DCFS Bureau of the Medical Director scheduled a series of four "D-Rate Town Hall" meetings for all foster parents, relative caregivers, and adoptive parents. The meetings on May 4, 2010 in Lancaster, June 8, 2010 in Glendora, and August 3, 2010 in central Los Angeles were well attended and the agenda included updates about the D-Rate Program. In addition, caregivers had many opportunities to discuss difficulties faced when meeting the needs of children for whom they are responsible, and received valuable feedback from professional staff and each other. The fourth meeting is scheduled for November 3, 2010 in Lakewood.

- On August 13, 2010, representatives from DMH, DCFS and Exodus Recovery Urgent Care Center (Exodus) met for preliminary discussions regarding a plan to provide urgent mental health care services to DCFS adolescents ages 16 through 17 years. A number of additional meetings with the departments and Exodus have occurred to develop a Memorandum of Understanding, and an expedited response protocol between DMH Psychiatric Mobile Response Team (PMRT) and DCFS. In addition, DCFS will provide "DCFS 101" training to

Exodus and PMRT staff in anticipation of the increased collaboration. DMH is also in the process of amending the Exodus contract to provide urgent mental health care services to DCFS children ages 13 and above. These services are expected to be available by January 2011, following the necessary renovations to the Exodus facility.

- DMH Wraparound Administration has begun a series of technical assistance site visits with Wraparound providers in order to improve the utilization of Early Periodic Screening Diagnosis and Treatment (EPSDT) funds associated with Wraparound programs. These site visits will be performed across all 34 Wraparound agencies over the course of the next year. DMH Child Welfare Division staff, in conjunction with DMH Service Area Administrations, has initiated a series of technical assistance site visits with Katie A. mental health providers to examine their claiming practices to improve the maximization of Katie A. contracts. These visits will begin in Service Planning Area (SPA) 3 and will continue until all 64 Katie A. providers have been visited. DMH has provided contract amendments, totaling approximately $10 million, to a set of Wraparound providers in order to enhance their capacity to perform Wraparound services. This brings the total EPSDT Wraparound allocation to over $60 million.

- DMH and DCFS staff met with three contract providers to begin negotiations to provide intensive home based services to Los Angeles County DCFS children placed in San Bernardino County. It is anticipated that contract amendments will be forthcoming for a total of approximately $1.5 million.

- Department representatives participated in a two-day meeting with the Katie A. Advisory Panel on September 15 and 16, 2010 to discuss the Core Practice Model (CPM), intensive mental health services for children in Foster Care/D-Rate homes, Quality Services Review (QSR), Multidisciplinary Assessment Team (MAT) case review and overall Strategic Plan implementation issues.

- Training for the Coordinated Services Action Team (CSAT) Redesign and revised Mental Health Screening Tool (MHST) has been completed in SPA 7 and is underway in SPA 6.

- DCFS continues to develop and maintain the Katie A. website.

- DCFS has now hired 81 of the 81 positions allocated in the Strategic Plan, and DMH has hired 38 of the 42 positions allocated.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan, are described below.

OBJECTIVE NO. 1

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health service needs. Below are the Screening and Assessment components of the Plan:

- *Medical Hubs (Hubs)*
- *Multidisciplinary Assessment Team (MAT)*
- *Consent/ Release of Information*
- *D-Rate*
- *Resource Management Process (RMP)*
- *Coordinated Services Action Team (CSAT)*
- *Referral Tracking System (RTS)*
- *Benefits Establishment*
- *Team Decision-Making (TDM)*
- *Specialized Foster Care (SFC)*

Medical Hubs

From July 2009 through April 2010, 82 percent of newly detained children received an initial medical examination at a Medical Hub.

DCFS continues to improve child health outcomes for DCFS children by ensuring that 100 percent of the priority populations of DCFS children are referred to and served by the Hubs. DCFS has defined the priority populations as:

- Newly detained children placed in out-of-home care;
- Children who are in need of a forensic evaluation to determine abuse and/or neglect; and,
- Children with special health care issues that need a follow-up exam, i.e., diabetes, hemophilia, developmental delay, etc.

On August 24, 2010, August 27, 2010 and September 21, 2010 the Hub Directors presented forensic evaluation and forensic interviews to newly hired Children's Social Workers (CSWs). Simultaneously, representatives of the DCFS Bureau of the Medical Director presented an overview of the Utilization of Medical Hub Procedural Guide, which included the procedures for referring children to Hubs and reinforced the use of the Hubs for consultation.

DCFS, Department of Health Services (DHS), DMH, and the Chief Executive Office (CEO) managers have met with all seven Hubs: High Desert Health System Multi-Service Ambulatory Care Center, Harbor-UCLA Medical Center Hub, Children's Hospital Los Angeles, LAC+USC Medical Center Hub, Martin Luther King Jr. Multi-Service Ambulatory Care Center, LAC+USC East San Gabriel Valley Satellite Hub, and the Olive View-UCLA Medical Center Hub. The Hub meetings are held to increase collaboration, ensure a strong understanding of Hub operations, and to plan for improved access and service delivery.

In addition, the County has taken steps to improve the continuity of care from the Hubs and has begun the development and implementation of an Enterprise Medical Hub (E-mHUB) system. The E-mHUB Project Workgroup continues to convene weekly to ensure that Saga Technology Inc. meets its deliverables.

Coordinated Services Action Team Redesign Rollout and Training Schedule

On May 1, 2009, CSAT was implemented in SPA 7 (Belvedere and Santa Fe Springs). On August 1, 2009, CSAT was implemented in SPA 6 (Compton, Wateridge, and Vermont Corridor). SPA 1 (Lancaster and Palmdale) implemented CSAT in September 2009, and SPA 3 (El Monte and Pomona) implemented CSAT on April 1, 2010.

In response to the January 19, 2010 motion from Supervisors Molina and Knabe, DCFS and DMH staff reviewed a sample of 51 children's cases from the DCFS Santa Fe Springs Regional Office for mental health screening, referral, and start of mental health services. The cases were randomly selected from newly detained children (25 cases) and newly opened non-detained children (26 cases). As a result of the case review, the Child Welfare MHST, the RTS and the CSAT Screening and Assessment Policy and related DMH policy were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs.

The MHST was revised to distinguish the acuity of a child's mental health needs and was piloted in SPAs 7, 6, 1, and 3 in May 2010. The pilot results revealed that 76 percent of the CSWs indicated that the revised MHST was easier to complete. The RTS was revised to track compliance and timelines for screening, referral, and receipt of mental health activities for newly detained children, non-detained children, and open cases.

The DCFS CSAT mental health screening and referral policy was revised to reflect the CSAT redesign process. CSAT redesign training was provided to SPA 7 in August 2010 and the revised mental health screening, referral, and service linkage

process and RTS system "trial month" phase was implemented on September 1, 2010. Formal implementation of the CSAT redesign will begin on October 1, 2010. In addition, the redesign has delayed the rollout of CSAT to DCFS offices not yet trained. Those offices already trained and implementing CSAT (SPAs 1, 6, 7, El Monte and Pomona) are being retrained and will implement the new procedures first, followed by the remaining offices.

CSAT staff and regional administration convene CSAT "pre-meets" prior to beginning training in each office. The pre-meet familiarizes regional management with the CSAT process and identifies their respective strengths and challenges, ensuring that training will be targeted to address the specific needs of each regional office. Initial pre-meets have been held in the Belvedere, Compton, Wateridge, and Vermont Corridor regional offices and the remaining pre-meet dates are to be determined.

The training rollout per office is depicted in Table 1.

Table 1: CSAT Redesign Training and Rollout Schedule

DCFS Office	*Training Month*	*Trial Month*	*CSAT Roll Out*	*Referral Tracking System Report to Board*
Belvedere, Santa Fe Springs	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct .2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster, Pomona, El Monte	Sept. – Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Pasadena, Covina Annex (Asian Pacific and American Indian Units only), Glendora	Oct. – Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
Metro North	Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011
West Los Angeles (and Deaf Services)	Dec. – Jan. 2011	Feb. 2011	Mar. 2011	May 2011
Lakewood, Torrance	Jan. – Feb. 2011	Mar. 2011	Apr. 2011	June 2011

San Fernando Valley, Santa Clarita	Feb. – Mar. 2011	Apr. 2011	May 2011	July 2011
Medical Case Management Services	Mar. – Apr. 2011	May 2011	June 2011	Aug. 2011
Emergency Response Command Post	May 2011	June 2011	July 2011	Sep. 2011

CSAT SUCCESS STORY

A 17-year-old youth came to the attention of DCFS due to his mother's history of domestic violence and the teen's aggressive behavior towards her. Due to his escalating behavior, his mother felt helpless and was willing to have the teen placed out of her home. A TDM meeting was held and it was determined that the teen required urgent linkage to mental health services.

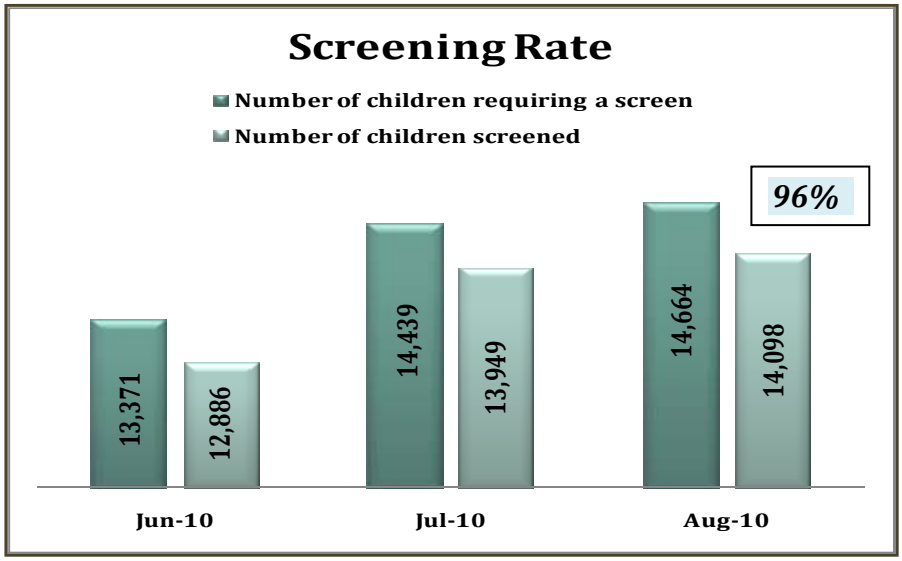
The Service Linkage Specialist (SLS) submitted the referral packet to DMH Specialized Foster Care staff, who immediately initiated a search for a mental health provider. Unfortunately, once a provider was established, the mother's Medi-Cal plan required a $500 co-payment, which she was unable to pay. With the assistance of the Department of Public Social Services (DPSS) Linkages Liaison, the teen applied for Medi-Cal benefits and was able to obtain individual benefits, thereby eliminating the $500 co-payment obligation. As a result, in-home mental health services began immediately and the teen remained in his home.

Referral Tracking System

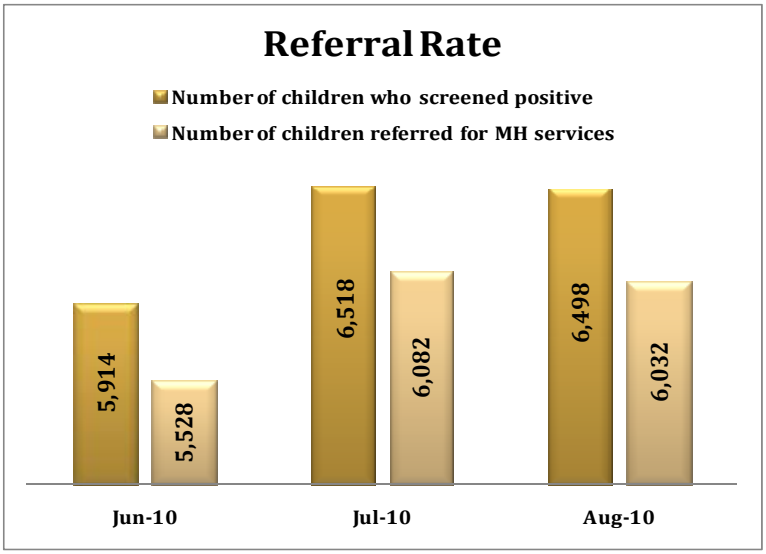
The RTS is operational in DCFS and DMH in a total of nine DCFS regional offices in SPAs 1, 3, 6, and 7. The RTS required redesign to reflect changes in the CSAT policy and procedures. The redesigned RTS will provide data on the completion of the mental health tool for screening, referral, and start of service activity for children with acute, urgent, and routine mental health needs. In addition, the RTS will track the annual re-screening of children in open cases with previous negative screens and who are not currently receiving mental health services. The RTS trial began on August 23, 2010, in preparation for the September 1, 2010 CSAT redesign trial month in SPA 7.

As of the August 31, 2010 CSAT/RTS Monthly Report, 14,098 children received mental health screens, since implementation on May 1, 2009, yielding a 96 percent screening

rate.* The mental health screening rate is tracked through the RTS for referral and mental health service linkage.



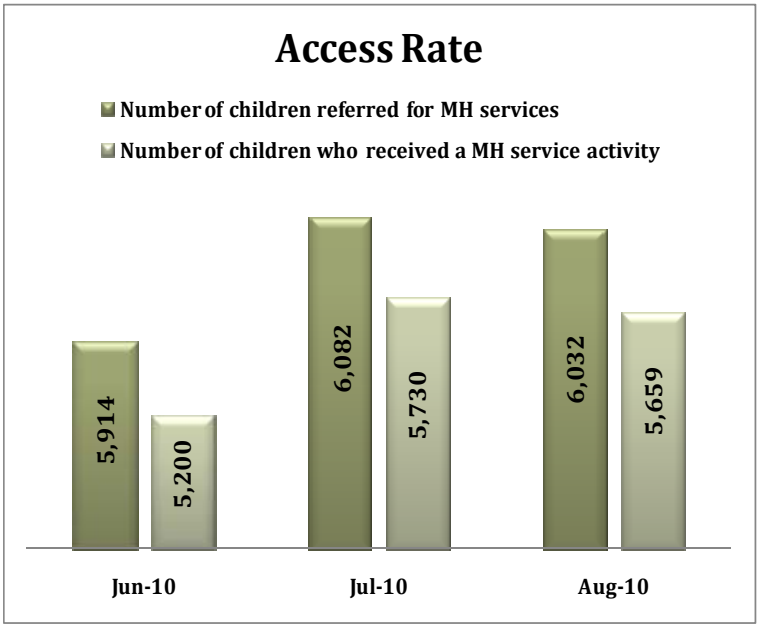
*The number of children that required screens is defined as a) the number of newly detained children (Track 1) with a case opening in the month; b) the number of newly opened non-detained children (Track 2) with a case opening in the month; c) the number of children in an existing open case (Track 3), not currently receiving mental health services, with a case plan update due or a behavioral indicator identified requiring the completion of a Child Welfare Mental Health Screening Tool (MHST) within the month. Out of the total number of children reported, the number of children requiring screens was reduced by the number of children in cases (Tracks 1, 2 and 3) that were closed during the screening, referral and service linkage process.



- As of the August 31, 2010 Monthly Report, out of the **6,498** children who screened positive, **6,032** children were referred for mental health services at a **95 percent** referral rate.**

**The rate of referral reflects the number of children who screen positive minus the number of children who are determined to be privately insured divided by the number of children referred to mental health services. The number of children referred for mental health services can be affected by the number of children with a closed case, deceased, and/or AWOL at the time of referral or still pending referral.

- As of the August 31, 2010 Monthly Report, out of **6,032** children referred for mental health services, **5,659** children received a mental health service activity within 30 days of the referral at a **94 percent** access rate.



Multidisciplinary Assessment Team

In June 2010, 84 percent of all MAT eligible newly detained children Countywide were referred to MAT. From October 2009 to June 2010, there were 3,456 MAT referrals and 2,733 MAT assessments completed.

In June 2010, seven DCFS offices referred 90 to 100 percent of all MAT eligible children and eight DCFS offices referred 80 to 89 percent of all MAT eligible children. Six offices referred between 70 to 79 percent of all MAT eligible children and only one office is currently below 70 percent. Seven of the eight SPAs are referring over 70 percent of eligible children. SPA 1 referral rates lag behind due to provider capacity issues. The rate of MAT compliance is depicted in Table 2.

Table 2: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	50	23	46%
SPA 2	66	61	92%
SPA 3	71	59	83%
SPA 4	43	38	88%

SPA 5	14	13	93%
SPA 6	106	91	86%
SPA 7	60	48	80%
SPA 8	67	59	88%
Total number of DCFS MAT referrals:	**477**	**392**	**82%**

*Cumulative includes all June 2010 MAT referrals within each DCFS office and SPA.

MAT staff (DMH, DCFS and MAT agencies) meet at the SPA level on a monthly basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Operations Workgroup, comprised primarily of experienced MAT providers, DCFS, and DMH managers, is working to standardize and streamline the MAT process, improve the quality of MAT reports and overcome barriers that prevent MAT agencies from completing the Summary of Findings (SOF) Report in time to be considered by the Court for the dispositional hearing. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders of the date to the MAT agencies. In addition, DCFS MAT Coordinators work closely with the Dependency Court attorneys to ensure that children have the appropriate consents to receive needed services.

MAT staff and other stakeholders have also met to discuss the needs for timely linkage to mental health services. This meeting resulted in the creation of the MAT Linkage Workgroup. This workgroup is tasked with ensuring that children with mental health needs are adequately linked to services. The guidelines are being created, so that each MAT agency understands their new responsibility regarding timely and appropriate linkage.

DMH and DCFS have issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol, MAT checklist, and MAT CSW Interview Survey. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT program. DMH and DCFS are also convening a MAT Best Practices Workgroup to further refine the assessment process and ensure the MAT SOF Report is completed and in line with recommendations made by the Children's Services Investigation Unit. Furthermore, DMH has planned a series of trainings for MAT providers to improve their understanding of needs and strength-based assessments consistent with the CPM.

To date, DMH MAT Coordinators have completed a total of 211 MAT Quality Improvement (QI) checklists. The checklists represent their findings based upon a review of the MAT SOF. QI checklists were received from the eight SPAs. The MAT QI checklist calls for yes/no responses within eight domains. The results of the MAT QI checklists are summarized below.

Results within MAT QI domains:

- 87 percent of the SOFs reviewed showed that the assessors demonstrated reasonable efforts to engage all the stakeholders in multidisciplinary activities to support the information gathering/assessment process;
- 86 percent showed the SOF Report adequately assessed all of the MAT domains of functioning;
- 91 percent showed the SOF Report contained adequate description and information;
- 90 percent showed the SOF final report was completed within 45 days;
- 89 percent showed the strengths of the children, family, and other caregivers were adequately described;
- 91 percent showed the needs of the children, family, and other caregivers were adequately described;
- 94 percent showed the recommendations made in the report were consistent with the assessment information; and
- 97 percent showed the recommendations were specific enough to be efficiently implemented.

Overall, 91 percent of the individual domain ratings were positive.

MAT SUCCESS STORY

The MAT Coordinator in the Pomona office worked diligently to provide support to the CSW in a complex needs case. She assisted the CSW in completing the referral form to a special needs program offered by Pacific Clinics and kept the child's mother updated on the status of the referral to the program. In addition, the CSW followed up

with the child's mother regarding the child's slurred speech and engaged the Public Health Nurse to assist with identifying a neurologist. The MAT Coordinator ensured that all of the child's needs were addressed and team members were kept informed of the child's status. This is a great example of the assistance and coordination CSAT members bring to CSWs.

Consent/Release of Information

DCFS and DMH, with their respective County Counsels, developed procedures and forms to provide for the consent of mental health services for referred children, as well as the authorization to release protected health information for purposes of children's care and coordination of services. Recommendations from children's and parents' attorney groups were incorporated and the Children's Law Center (CLC), the Los Angeles Dependency Lawyers, County Counsels, and DMH and DCFS management approved the revisions. Consent forms are in the process of being revised to reflect the Court's language, and seeking approval from the DMH Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer. In addition, CLC and County Counsel agreed to write letters that provide explanation of law regarding consent and protected health information in an effort to clarify for providers what they may and may not share with DCFS and DMH staff for purposes of children's care and coordination of services. The DCFS training section will train staff from both Departments on the revised consent and release of information forms. Finally, as a result of consultation with Regional Center, DCFS, DMH, and Regional Center management are participating in a Consent Sub-Workgroup to modify the language in the consent forms and standardized court language and DCFS policy to ensure the needs of all children are appropriately addressed.

The DMH Practice Guidelines related to consultation requests involving adult mental health information is completed and being reviewed by County Counsel. The Guidelines include information on the formation of multidisciplinary teams that may allow DMH co-located staff and service providers to share adult caregiver mental health information to assist DCFS in providing protection to children and support to families. DCFS has agreed to create a comparable policy to clarify which situations merit consultation with DMH and what information can be shared within this context.

Benefits Establishment

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the Medi-Cal Eligibility Data System (MEDSlite) benefits establishment system. MEDSlite is a condensed version of the Medi-Cal Eligibility Data System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT

Coordinators that serves as an instructional guide for the use of MEDSlite, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

Although the MEDSlite system is helpful in providing a child's Medi-Cal eligibility status "at a glance", one of the limitations of the system is that it does not provide the issue date of a child's Medi-Cal card, needed most by DMH providers for mental health service billing.

With staff reductions at the State level, disruptions in service are occurring as it takes longer to enroll them in full-scope Medi-Cal. To further complicate the process of establishing Medi-Cal and maintaining enrollment, eligibility staff at DCFS can only access the Medi-Cal database for foster care and adoption services Medi-Cal. DCFS eligibility staffs do not have access to information regarding the type of Medi-Cal coverage for non-detained children. The inability of DCFS eligibility staff to address all Medi-Cal issues has presented challenges with enrolling children in mental health services in a timely manner.

DCFS and DPSS have built a productive partnership through the use of DPSS Linkages staff that has been very helpful. CSAT staff work very closely with Linkages staff to obtain and secure Medi-Cal services for children without Medi-Cal that are otherwise eligible.

D-Rate

In addition to the D-Rate Program's continued work to review and ensure mental health services for D-Rate children, the duties of the DCFS D-Rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning, special placement requests and approvals, and service coordination for other high-need children.

As of July 2010, there were a total of 1,477 children in DCFS care who were receiving a D-Rate, which has been gradually declining over the last several years.

Team Decision-Making/Resource Management Process

DCFS has completed 4,428 TDMs from April through June 2010. This number was almost identical from the previous three months as there were a total of 4,427 TDM's conducted from January through March 2010. Additionally, DCFS completed a total of 476 RMPs on 61 percent of youth entering a group home, 71 percent of youth replaced

and 63 percent of youth exiting a group home. This was an increase of 27 RMPs from the previous three months (January through March 2010).

Finally, DCFS continues efforts to phase in TDMs at the Emergency Response Command Post (ERCP). There were a total of 25 TDMs completed from April through June 2010. Preliminary data reflects positive outcomes: 23 (92 percent) of the ERCP TDMs resulted in children remaining home with their respective caregivers; and 16 (64 percent) of the ERCP TDMs convened had the participation of community-based agency partners.

Specialized Foster Care

The DMH SFC Care co-located staff responds to requests for consultation from DCFS CSWs, provides referral and linkages to community-based mental health providers, and participates in the CSAT process in those offices where CSAT has rolled out. Moreover, all SFC co-located staff (a total of 70 clinicians) were trained in Trauma-Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, and provide this treatment on a case-by-case basis. Currently, DMH has 178 co-located staff in 18 DCFS regional offices.

OBJECTIVE NO. 2

Mental Health Service Delivery

DMH has been working with its provider community to improve capacity and utilization of mental health services, particularly among those providers, now totaling 64, who have received a Katie A. related contract (including Wraparound, MAT, Treatment Foster Care (TFC), Comprehensive Children's Services Program, and Basic Mental Health Services). In total, these contracts now provide for over $100 million of targeted mental health services for DCFS children. In addition to these targeted contracts, DMH children's providers also use their general service contracts to provide needed services to DCFS children.

Wraparound

On May 1, 2009, the County began the implementation of Tier II Wraparound, an expansion of the existing Wraparound Program.

As of July 30, 2010, 1,088 children have been enrolled in Tier II Wraparound, which is 106 percent of our target (1,025). The feedback from the regional offices has been very positive. As a result of the recent economic downturn, many providers have not been

hiring/expanding their staff to handle the increase in referrals from the County. However, Wraparound Providers have now begun hiring again and are moving forward with expanding capacity to meet the demand.

Although Tier II is exceeding its target, as of June 2010, the Tier I enrollment has dropped from 1,059 to 1,043. The current census is expected to increase significantly with the implementation of the Residentially-Based Services (RBS) Demonstration Project slated to begin in September 2010.

Additionally, when Tier II was being developed there was discussion of how Tier II would impact Tier I. Although it is still too early to discuss a relationship, the belief is that Tier II will intervene much earlier in a family's life resulting in fewer children requiring Tier I level services.

The Wraparound Administration has also implemented a review of the Wraparound Case Rate for appropriateness and for opportunities to increase the use of EPSDT. In May 2010, a workgroup was formed that included representatives from CEO, Auditor-Controller's Office, DCFS Finance, Probation, DMH, and several Wraparound Provider agencies. The workgroup developed the methodology and the process for evaluation. On October 4, 2010, all Wraparound providers will receive instructions to provide their case rate data for review. Upon receipt, the Wraparound Administration will analyze, report findings, and discuss next steps.

Treatment Foster Care

The County's TFC Program is another intensive mental health service program, originally discussed in the Katie A. CAP. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 TFC beds by January 2008. A proposal to develop 300 beds by December 2012 was established as the new target: 220 beds of Intensive Treatment Foster Care (ITFC) and 80 beds of Multi-dimensional Treatment Foster Care (MTFC). The Program continues to grow as placements have improved since the last report. Eight children have currently been placed compared to the three placed in the previous quarter. Each Foster Family Agency (FFA) with a vacancy has begun reviewing the list of available youth needing TFC placement. In addition, TFC outcomes continue to show a positive trend with two youth successfully transitioning to a lower level of care and none returning to a group home or psychiatric hospital since the last report.

There has been a small increase of three certified TFC homes. As seen in the last quarter, the number of potential homes has continued to rise. With the recruitment of 12 new homes, the number of upcoming homes has increased from 40 to 52. The

challenge for the TFC program remains the length of time needed to recruit, certify, and train TFC resource families. It can take between two to six months for a resource family to be fully certified, complete the adoption home-study, and receive the 40 hours of mandatory training.

Overall, TFC program development is growing. The nine FFAs that received contracts in April 2010 have begun the process of hiring and developing their treatment teams according to State regulations for intensive treatment foster care. The treatment teams consist of a case manager/program supervisor, in-home support counselor, and licensed therapist that work together to provide 24/7 intensive support services to the child and the TFC foster parent. The team members must undergo 16 to 40 hours of specialized training, depending upon their duties. With the TFC teams in place, the agencies are now tackling the time-consuming task of recruiting, certifying, and training TFC foster parents. The foster parents are also considered part of the treatment team, therefore, once recruited and certified they must also complete a mandatory 40-hours of training to work with youth with severe emotional and behavioral problems.

Table 3: TFC Placement and Capacity (as of 8/20/10)

Agency	Total No. of Placed Children	Total Certified Homes	Certified Homes Vacancies	**Inactive Homes	Upcoming Beds (cert. incomplete)
Intensive Treatment Foster Care (ITFC)					
Five Acres	10*	12*	3	1	9
ChildNet	5	8	1	2	1
Olive Crest	1	2	0	1	0
Penny Lane	0	0	0	0	11
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	0	0	0	2
The Village	2	3	1	0	4
CII	0	0	0	0	5
David and Margaret	0	0	0	0	4
Vista Del Mar	0	0	0	0	4
Hathaway-Sycamore	0	0	0	0	0
Ettie Lee	0	0	0	0	0

SUB TOTAL	18*	25*	5	4	40
Multi-dimensional Treatment Foster Care (MTFC)					
CII	5	7	2	0	0
Penny Lane	4	9	2	3	10
ChildNet	1	5	4	0	0
David and Margaret	0	0	0	0	2
SUB TOTAL	10	21	8	3	12
GRAND TOTAL	**28**	**46**	**13**	**7**	**52**

* Three children placed in one ITFC home **Per Agency request

DMH has added capacity within the MTFC program to serve children as young as six years old. In addition, DMH has also expanded MTFC capacity from two SPAs to five SPAs. TFC program staff is assisting in recruitment with more proactive outreach to existing licensed foster parents that might be interested in working with the TFC target population.

ChildSTEPs

DMH has contracted with UCLA to partner on a three-year research project which will examine the use of various evidence-based practices for children and adolescents as compared to usual or conventional treatment approaches. This project, known as ChildSTEPs, will provide substantial training, consultation and technical assistance, and tracking of outcomes for those mental health providers participating in the study and will inform future planning of children's mental health services.

To date, providers have been selected to participate in this project and the initial week of training in the model was conducted in August 2010.

DMH has also begun a large scale transformation of mental health services related to the Mental Health Services Act Prevention and Early Intervention Program. As part of this initiative, children's mental health providers are being trained in a variety of evidence-based practices, including Trauma-Focused Cognitive Behavior Therapy, Triple P (Positive Parenting Program), Child Parent Psychotherapy, Depression Treatment Quality Improvement (DTQI), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Managing and Adapting Practice (MAP), and Seeking Safety.

OBJECTIVE NO. 3

Funding of Services/Legislative Activities

Currently, we anticipate approximately $22 million in fiscal year savings from 2009-10. The savings are primarily due to vacant Wraparound slots. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings should decline in the out years.

As we have done with prior year savings, CEO has rolled the Fiscal Year (FY) 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 in support of the incremental rollout of the Strategic Plan.

The County met with the Special Master toward the end of July 2010 to discuss the Special Master's work plan for concluding negotiations between the Katie A. Plaintiffs and the State by November 1, 2010. In that July 21 meeting, the Special Master discussed plans to contract with a pool of consultants that could provide expertise in developing new approaches for the delivery of Medicaid EPSDT services to meet the needs of the plaintiff class. The County supports a detailed analysis of the various service delivery and funding models to determine the most cost-effective manner of delivering intensive mental health services to Katie A. class members. DMH is continuing to participate in the negotiations led by the Special Master and this forum remains the County's most viable opportunity to maximize revenue reimbursement to the County.

OBJECTIVE NO. 4

Training

DMH and DCFS have worked closely together to develop and implement the necessary training components related to the Strategic Plan, including:

- On May 27–30, 2010, a Coaching and Mentoring Pilot was held for five DCFS offices and selected DMH staff. Casey Family Programs sponsored the training for staff from the Pasadena, Lakewood, Compton, Wateridge, and Chatsworth offices. This core training provided staff with key skills and techniques to become office-based coaches starting with Emergency Response (ER) staff;

- An ER specific Coaching Model is being developed in partnership with California State University, Long Beach. A three-day follow-up coaching training was held

August 31–September 2, 2010. The tentative coaching roll-out for the five pilot DCFS offices is:

- o Lakewood: September 14, 2010, October 5, 2010, November 9, 2010, and December 14, 2010;
- o Compton: September 16, 2010, October 7, 2010, November 9, 2010, and December 14, 2010;
- o Wateridge: September 21, 2010, October 19, 2010, November 18, 2010, and December 16, 2010;
- o Pasadena: September 23, 2010, October 21, 2010, November 18, 2010, and December 16, 2010; and
- o Chatwsorth: September 28, 2010, October 26, 2010, November 23, 2010, and December 21, 2010.

- The Enhanced Skill-Based Training Pilots were completed on July 29, 2010. The Inter-University Consortium Trainers are incorporating feedback from the DCFS and DMH staff who attended the Pilot Trainings. This curricula is also being modified to address Katie A. Panel member feedback and was discussed at the September 2010 Panel Retreat. The office-based roll-out schedule is slated for early fall and is being drafted for the DCFS Executive Team's review and approval.

- The refinement and adaptation of the DCFS/DMH CPM into a desk guide that aligns both departments policies and procedures. The CPM desk guide will articulate how staff will integrate the key competencies of engaging and teaming, while using a strengths-based approach into daily practice.

- On August 17, 2010, DMH and DCFS provided a joint training to Wraparound and SFC staff on the Child Assessment Needs and Strengths (CANS) tool. In addition, needs-strength based mental health assessment training will resume for MAT Providers and DMH co-located staff.

OBJECTIVE NO. 5

Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,680 (January 2010) to 15,375 (July 2010).

Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

As of January 2010, individual CSW generic caseload sizes were reduced from an average of 26 to 22.48. An increase in this average in July 2010 brought the average caseload to 25.47 children per social worker.

As of January 2010, the ER caseload was reduced from an average of 24 to 19.25. This service component showed a significant decrease through July 2010, bringing the current referral average to 15.19. The escalating trend in caseload averages is due to the increased number of ERCP referrals received within the past six months, associated workload tied to heightened safety measures in emergency response activities and investigations, and the need to address an increasing backlog of emergency response investigations.

OBJECTIVE NO. 6

Data and Tracking of Indicators

The departments, with approval from County Counsel, implemented a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The SAS Dataflux system is being used for matching DMH and DCFS client data. This software has undergone extensive parallel testing, with the assistance of the Internal Services Department, to improve the validity of client matches. The SAS Dataflux system is now in full production, whereby matches can be conducted more frequently and the departments have agreed to conduct weekly matches of client information.

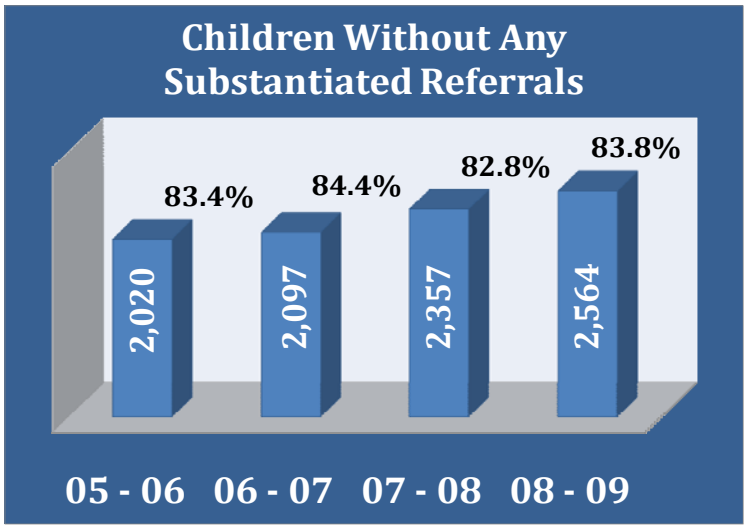
The Katie A. Advisory Panel informed the Court of our agreement on the Safety and Permanency Exit Indicators in their August 18, 2010 Report for Court. Discussions on the mental health screening, assessment, and service delivery exit indicators continue. Should the Court agree with the County and Panel's recommendations on the Safety and Permanency Exit Indicators and targets, the first step in identifying measurable exit

criteria by which to evaluate the County's progress in complying with the Katie A. lawsuit would be accomplished.

DATA OUTCOMES

SAFETY	***PERMANENCY/ REDUCED OUT-OF-HOME CARE***

The intensified collaboration of the departments to advance the objectives of the Strategic Plan simultaneously impacts DCFS key goals to: 1) improve child safety; 2) decrease timelines to permanency and reduce reliance on out-of-home care; and 3) improve child well-being. A sample of Katie A. Safety and Permanency Exit Indicators for class members (those receiving mental health services) are depicted below.



Safety Indicator 1:

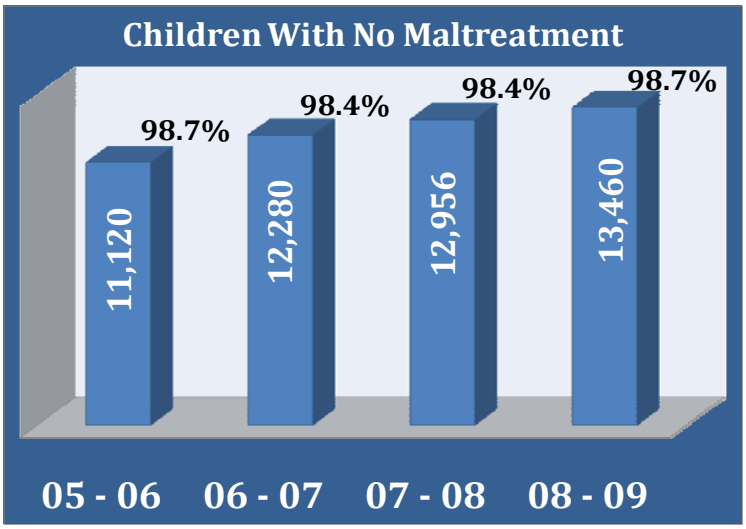
Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

This indicator has remained fairly stable over the last few years at roughly 83 percent and demonstrates that the majority of children are remaining safely at home.

Safety Indicator 2:

Of all children served in foster care in the fiscal year receiving mental health services, how many did not experience maltreatment by their foster care providers?

Again, this indicator has remained stable at 98 percent indicating that the majority of children in foster home settings experienced no substantiated foster parent maltreatment.



Permanency Indicator 1:

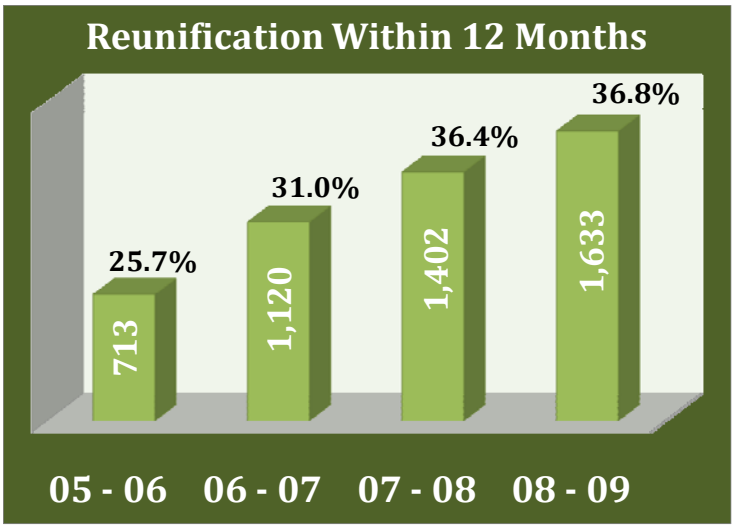
Median length of stay for children in foster care receiving mental health services.

This indicator reflects meaningful improvement – a 23 percent decline – in median days in foster care from FY 2005-06 to FY 2008-09.

Permanency Indicator 2:

Reunification within 12 months for children receiving mental health services.

Dramatic improvements in reunification are evident – over 100 percent increase from FY 2005-06 to FY 2008-09.



OBJECTIVE NO. 7

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the: (1) successful adoption by your Board and the Federal District Court of the Strategic Plan; (2) acceptable progress on a discrete set of agreed upon data indicators; and (3) a passing score on the QSR.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by your Board, the Advisory Panel, and Plaintiffs' attorneys, and, as previously noted, the Strategic Plan was approved by the Federal District Court on July 22, 2009. This notes the first time since the inception of the lawsuit that a County developed plan for Katie A. has been approved by the Court, which is a significant achievement in itself for the County and identifies a practical timeline with objective criteria for exiting the lawsuit.

Quality Services Review

QSR is an in-depth, case-based quality review process focused on integrated child welfare and mental health practices involving dependency and concurrency for children in care. Review findings will be used by the departments to stimulate and support efforts to improve practice for children, youth, and families receiving child welfare and children's mental health services in Los Angeles County. Review findings identify

current strengths and accomplishments, practice challenges, and limiting conditions, as well as opportunities for advancing practice and improving local conditions for better outcomes.

The QSR process will take place in three phases. Phase I activities, which have included the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan have been completed as projected by July 2010.

In the Belvedere QSR Pilot completed in July 2010, a sample of 14 randomly selected cases was reviewed and an average of 8.5 children, youth, caregivers, family members, service providers, and other professionals were interviewed per case. Overall, the children in the cases reviewed were found to be safe, healthy, and well cared for. On the Child and Family Status Indicators, which include Safety, Well-Being, and Stability/Permanency, 85 percent of the cases had favorable outcomes, with over 98 percent of the children identified as being safe. The Practice Performance Indicators identified areas for improvement, including Engagement, Teaming, and Long-Term View. Other factors that were found to have an impact on outcomes included the positive correlation between case outcomes and continuity of the CSW; the utilization of trauma informed evidenced based treatments; the completion of early assessments that address the underlying needs of the child and family; implementing a team approach to treatment; and developing a shared vision with clear goals to be achieved for safe case closure. A technical review of the pilot test version of the protocol was performed. On August 5 and 6, 2010, the second set of 12 selected DCFS and DMH staff received QSR protocol training. Furthermore, the first "rollout" of the QSR was successfully accomplished on August 9-13, 2010 in the DCFS Santa Fe Springs Office.

QSR Phase II activities, which are to be completed by December 2012 have begun, including the commencement of the administration of the QSR across the 18 DCFS regional offices. Phase III activities, to be completed by December 2013, shall consist of any follow-up reviews that may be necessary to achieve passing scores. Advance preparations are also underway to implement the third set of trainings and the second "rollout" of the QSR from October 18-22, 2010 within the DCFS Compton Office. This is the last QSR review scheduled for the 2010 calendar year. The initial sequence of offices to undergo reviews in 2011 has been identified and "rollout" is expected to generally follow the order of the CSAT implementation and Enhanced Skill-Based Training.

The review provides an opportunity to understand what works well and where there is opportunity for growth. The departments have been developing a shared CPM, Enhanced Skill Based Training, and Coaching and Mentoring Program, so there is a

consistent method of practice in working with children and families. In addition to these change strategies, the departments will implement regional based improvement plans to strengthen practice and ensure quality services.

Summary Highlights

During the last three months, the County has continued to demonstrate significant progress toward meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Significant highlights from the last report include:

- DMH has initiated contract amendments with Wraparound Providers that will expand the County's capacity to provide Wraparound services for DCFS-involved children and youth by an additional 817 slots;

- DMH has begun a series of technical assistance site visits to work with Wraparound providers and other Katie A. funded mental health programs to improve utilization and reporting of Katie A. related funds; and

- DMH and DCFS have worked together to improve coordination and responsiveness to children and youth with urgent and acute needs for mental health services, including revisions to the mental health screening tool, policy and practice changes. Coordination has been enhanced between DCFS and DMH for the PMRT, Child Welfare, and DMH co-located staff, and initiation of and a contract is under development with an urgent care center to provide mental health crisis intervention services to DCFS involved children and youth.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Assistant Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:KH
LB:AM:mh

c: Executive Office, Board of Supervisors
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WILLIAM T FUJIOKA
Chief Executive Officer

December 30, 2010

To: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: William T Fujioka William T Fujioka by
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003);
- Enhanced Specialized Foster Care Mental Health Services Plan (2005);
- Findings of Fact and Conclusions of Law Order (2006), issued by Federal District Court Judge Howard Matz;
- Health Management Associates Report (2007); and
- Katie A. Corrective Action Plan (2007).

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

The Strategic Plan also provides that the Departments of Children and Family Services (DCFS) and Mental Health (DMH) inform your Board regarding any revisions to the implementation of the Strategic Plan. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents.

Previous quarterly reports were submitted on implementation activities in June 2009, September 2009, March 2010, July 2010, and September 2010. This memo serves as the sixth update to our progress in implementing the Strategic Plan. Due to the time required to compile the reports, particularly to obtain updates for the "Data and Tracking of Indicators" section, we will be transitioning to semi-annual reporting in 2011. Accordingly, the next report will be submitted on June 30, 2011.

Implementation Support Activities

- Greg Lecklitner, DMH District Chief, participated as a member of the Katie A. State Negotiations Team, which is working toward a settlement of the Katie A. State Case. The interest-based, decision-making process used in this matter has completed its work and the Special Master will soon be submitting recommendations to the Court. There is a possibility of a settlement agreement which would be of significant support to the work of the County in this matter.

- Training for the redesigned Coordinated Services Action Team (CSAT) and revised Child Welfare Mental Health Screening Tool (MHST) is complete for DCFS and DMH staff located at the offices of Belvedere, Santa Fe Springs, Wateridge, Compton, Lancaster, Palmdale, Pomona, El Monte, Emergency Response Command Post (ERCP), and Asian Pacific and American Indian units. Official implementation of CSAT and the revised MHST has begun in the Belvedere, Santa Fe Springs, Wateridge, Compton, Lancaster, Palmdale, Pomona, and El Monte offices.

- The Real Time Notification and Expedited Response Protocol, and Exodus Recovery Urgent Care Center (Exodus) Memorandum of Understanding (MOU) are currently being reviewed by County Counsel. Pending finalization of the MOU and the development of formal policy, many activities establishing joint, timely and skilled responses from DCFS and DMH staff to DCFS children experiencing a mental health crisis, are occurring as follows:

    - The DCFS/DMH Data Cube is now available to Psychiatric Mobile Response Team (PMRT) staff and other clearance procedures are in place to identify DCFS involvement for any child/youth who is the subject of a PMRT call;

    - Expedited and joint response between an Emergency Response (ER) Children's Social Worker (CSW) and PMRT for any child/youth who is the subject of a PMRT call and alleged abuse/neglect is available 24 hours a day/7 days a week, including regular business hours (Monday – Friday 9:00 a.m. to 5:00 p.m.) and after business hours;

    - Coordination of care and treatment will occur between the existing CSW and PMRT and will begin the next business day for any DCFS child/youth who is the subject of a PMRT call without allegations of abuse/neglect. In addition, the process to track and monitor this activity is in development;

    - DCFS 101 Training provided to Exodus management and staff as well as PMRT staff; and

    - Amendment of the mental health contract with Exodus to allow them to provide services to children and youth ages 13 and above.

- LAC+USC Emergency Department (ED), LAC+USC Medical Hub, Violence Intervention Program (VIP), DCFS, and DMH staff have collaborated to establish protocols to identify DCFS youth admitted to the ED or the hospital for mental health reasons and/or a psychiatric hold, the service delivery of such clients, and joint discharge planning.

- Development and implementation of the Core Practice Model (CPM) and enhanced training for DMH and DCFS staff to improve quality of assessments and interventions, and encourage teaming, with a shared focus on the needs and strengths of children and families.

- Collaboration between DCFS Child Welfare Mental Health Services (CWMHS) Division and the Bureau of Information Services management resolved the

long-standing technical challenges to permit the uploading of over 3,000 Psychotropic Medication Authorization (required for the administration of psychotropic medication) documents to the Child Welfare Services/Case Management System (CWS/CMS).

- DCFS and DMH Wraparound Administrations have begun a series of technical assistance site visits with Wraparound providers in order to improve the utilization of Early Periodic Screening Diagnosis and Treatment (EPSDT) funds associated with Wraparound programs. These site visits will be performed across all 34 Wraparound agencies over the course of the next year.

- To improve the maximization of Katie A. contracts, DMH Child Welfare Division staff, in conjunction with DMH service area administrations, initiated a series of technical assistance site visits with Katie A. mental health providers to examine their claiming practices. These visits have been completed for Service Planning Area (SPAs) 1, 3, and 4 and will continue until all 64 Katie A. providers have been visited.

- DMH has contracted with three mental health providers to deliver mental health services consistent with the CPM to Los Angeles County DCFS children placed in San Bernardino County.

- DMH, DCFS, and the Chief Executive Office (CEO) have convened workgroups to improve the implementation of the Treatment Foster Care (TFC) program and to address the mental health needs of those children placed outside of Los Angeles County.

- Department representatives participated in a two-day meeting with the Katie A. Advisory Panel on December 15 and 16, 2010 to discuss the CPM, intensive mental health services for children in Foster Family Agencies (FFAs) and D-Rate homes, Quality Services Review (QSR), TFC, Wraparound Case Rate, and overall Strategic Plan implementation issues.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan, are described below.

OBJECTIVE NO. 1

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health service needs. Below are the Screening and Assessment components of the Plan:

- *Medical Hubs*
- *Multidisciplinary Assessment Team*
- *Benefits Establishment*
- *Team Decision-Making*
- *Specialized Foster Care*
- *Coordinated Services Action Team*
- *Referral Tracking System*
- *Consent/ Release of Information*
- *D-Rate*
- *Resource Management Process*

Medical Hubs

In Fiscal Year (FY) 2009-10, 80 percent of newly detained children received an initial medical examination at a Medical Hub (Hubs).

DCFS continues to improve child health outcomes for DCFS children by ensuring that 100 percent of the priority populations of DCFS children are referred to and served by the Hubs. DCFS has defined the priority populations as:

- Newly detained children placed in out-of-home care;
- Children who are in need of a forensic evaluation to determine abuse and/or neglect; and
- Children with special health care issues that need a follow-up exam, i.e., diabetes, hemophilia, developmental delay, etc.

On September 15, 2010, a memorandum was issued by the DCFS Director and Medical Director which mandated all DCFS staff to refer all newly detained children to a Hub for initial medical examination. In addition to presentations held in August and September 2010 on the DCFS Utilization of the Medical Hubs Procedural Guide, representatives from DCFS, Department of Health Services (DHS) and DMH administration hosted local meetings to strengthen the referral to and the use of the Hubs for the priority populations.

Further, the County has moved forward with the development of the Enterprise Medical Hub (E-mHub) system to strengthen the continuity of care by the DHS-operated Hubs and to improve information sharing between DCFS and the Hubs. The E-mHub Project Workgroup continues to convene weekly to provide system development

recommendations to the contracted vendor, Saga Technology Inc. Currently, the Workgroup is developing the User Acceptance Testing for system functionality. Testing of approximately five categories is scheduled to be complete in December 2010, with full implementation in June 2011.

Coordinated Services Action Team Redesign Rollout and Training Schedule

On May 1, 2009, CSAT was implemented in SPA 7 (Belvedere and Santa Fe Springs). On August 1, 2009, CSAT was implemented in SPA 6 (Compton, Wateridge, and Vermont Corridor). SPA 1 (Lancaster and Palmdale) implemented CSAT in September 2009, and SPA 3 (El Monte and Pomona) implemented CSAT on April 1, 2010.

In response to the January 19, 2010 motion from Supervisors Molina and Knabe, DCFS and DMH staff reviewed a sample of 51 children's cases from the DCFS Santa Fe Springs Regional Office for mental health screening, referral, and start of mental health services. The cases were randomly selected from newly detained children (25 cases) and newly opened non-detained children (26 cases). As a result of the case review, the Child Welfare MHST, the Referral Tracking System (RTS), the CSAT Screening and Assessment Policy, and the related DMH policy were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs.

The MHST was revised to distinguish the acuity of a child's mental health needs and was piloted in SPAs 7, 6, 1, and 3 in May 2010. The pilot results revealed that 76 percent of the CSWs indicated that the revised MHST was easier to complete. In December 2010, the MHST was further revised to refine language that misleadingly indicated a child's need for urgent assessment from DMH, who subsequently determined the mental health need existed, but was not urgent. Subsequently, the RTS was revised to track compliance and timelines for screening, referral, and receipt of mental health activities for newly detained children, non-detained children, and open cases.

In addition, the DCFS CSAT mental health screening and referral policy was revised to reflect the CSAT redesign process. CSAT staff and regional administration convene CSAT "pre-meets" prior to beginning training in each office. The pre-meet familiarizes regional management with the CSAT process and identifies their respective strengths and challenges, ensuring that training will be targeted to address the specific needs of each regional office. "Pre-meets" for SPA 4 and Covina Annex began in October 2010 and ERCP in November 2010.

CSAT redesign training was provided to SPA 7 in August 2010 and the revised mental health screening, referral, and service linkage process and RTS system "trial month" phase was implemented on September 1, 2010. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. Data from SPA 7's trial month of CSAT redesign implementation will be reported to the Board in the December Monthly Report on the Mental Health Screening Process.

CSAT SUCCESS STORY

An ER CSW in Palmdale referred four children to Family Preservation (FP) for mental health services. Due to the lack of Spanish speaking providers in the Antelope Valley, the children were placed on a waiting list. As the ER CSW continued working with the family, it was determined that one of the children required urgent linkage to mental health treatment. Subsequently, the ER CSW consulted with the Service Linkage Specialist (SLS) and DMH FP to discuss mental health treatment options to prevent the child from being removed from their home, and as a result, DMH co-located staff is providing mental health services to all four children. The collaboration and teamwork by all involved made it possible to ensure the children remained at home and that their needs were met. The redesigned training rollout per office is depicted in Table 1.

Table 1: CSAT Redesign Training and Rollout Schedule

DCFS Office	Training Month	Trial Month	CSAT Roll Out	RTS Report to Board
Belvedere, Santa Fe Springs	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct .2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster, Pomona, El Monte	Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Covina Annex (Asian Pacific/American Indian Units only), Metro North	Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
ERCP	Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011

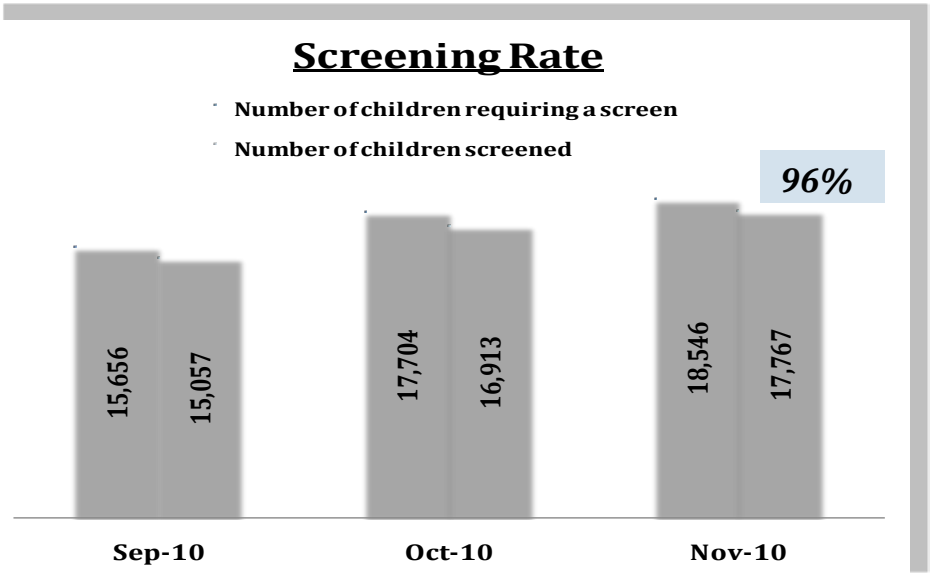
West Los Angeles, Deaf Services, Pasadena	Jan. 2011	Feb. 2011	Mar. 2011	May 2011
Lakewood, Torrance	Feb. 2011	Mar. 2011	Apr. 2011	June 2011
Glendora	Mar. 2011	Apr. 2011	May 2011	July 2011
Medical Case Management Services	Apr. 2011	May 2011	June 2011	Aug. 2011
San Fernando Valley, Santa Clarita, West San Fernando Valley	May 2011	June 2011	July 2011	Sep. 2011

Referral Tracking System

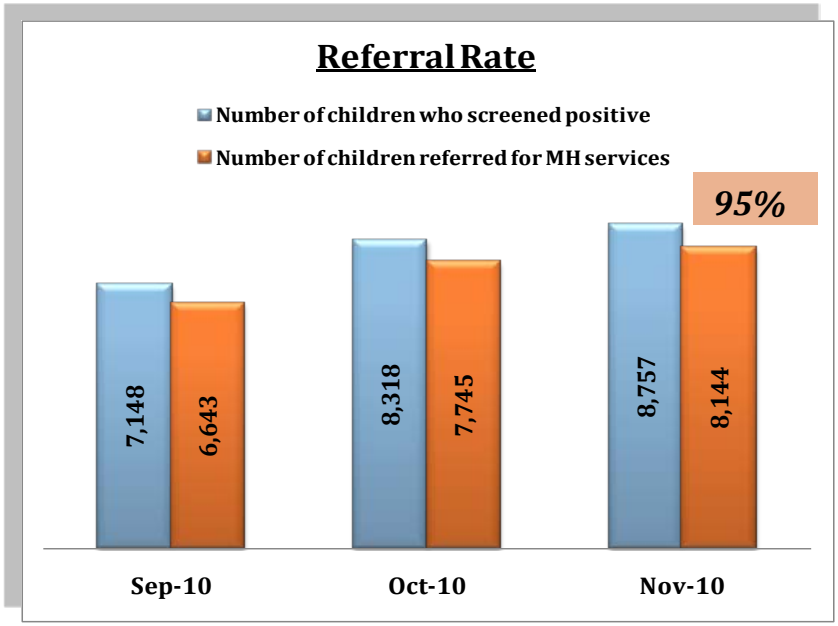
The RTS is operational in DCFS and DMH in a total of nine DCFS regional offices in SPAs 1, 3, 6, and 7. The RTS required redesign to reflect changes in the CSAT policy and procedures. The redesigned RTS has provided initial data on the completion of the mental health tool for screening, referral, and start of service activity for children with acute, urgent, and routine mental health needs in SPA 7 on September 1, 2010 and in SPA 6 on October 1, 2010.

In addition, the RTS will track the annual re-screening of children in open cases with previous negative screens and not receiving mental health services. The first revised report tracking mental health acuity and response in SPA 7 will be submitted to the Board on December 30, 2010.

As of the November 30, 2010 CSAT/RTS Monthly Report, 17,767 children received mental health screens since implementation on May 1, 2009, yielding a 96 percent screening rate.* The mental health screening rate is tracked through the RTS for referral and mental health service linkage.



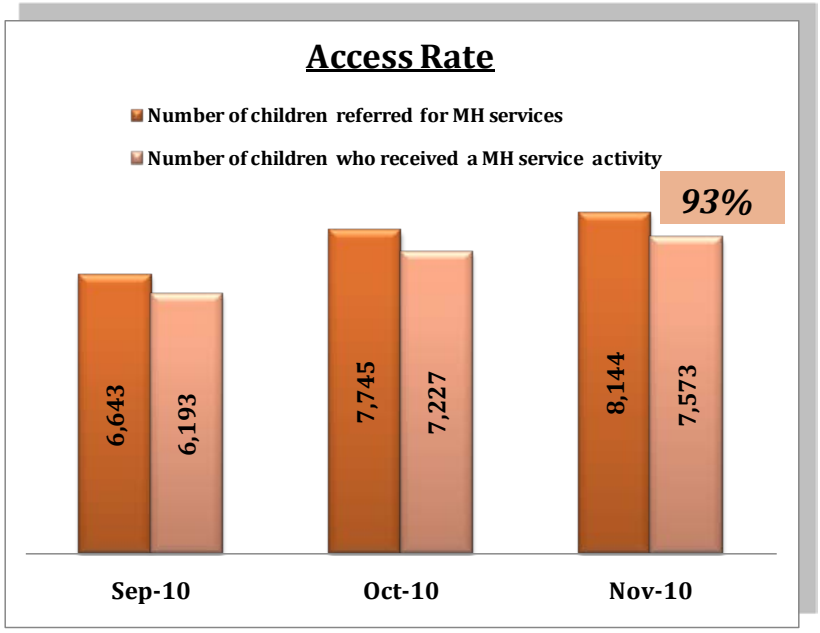
*The number of children that required screens is defined as a) the number of newly detained children (Track 1) with a case opening in the month; b) the number of newly opened non-detained children (Track 2) with a case opening in the month; c) the number of children in an existing open case (Track 3), not currently receiving mental health services, with a case plan update due or a behavioral indicator identified requiring the completion of a Child Welfare Mental Health Screening Tool (MHST) within the month. Out of the total number of children reported, the number of children requiring screens was reduced by the number of children in cases (Tracks 1, 2, and 3) that were closed during the screening, referral, and service linkage process.



As of the November 30, 2010 Monthly Report, out of the **8,757** children who screened positive, **8,144** children were referred for mental health services at a **95 percent** referral rate.**

** The rate of referral reflects the number of children who screen positive minus the number of children who are determined to be privately insured divided by the number of children referred to mental health services. The number of children referred for mental health services can be affected by the number of children with a closed case, deceased, and/or AWOL at the time of referral or still pending referral.

As of the November 30, 2010 Monthly Report, out of **8,144** children referred for mental health services, **7,573** children received a mental health service activity within 30 days of the referral at a **93 percent** access rate.



Multidisciplinary Assessment Team

In September 2010, 83 percent of all Multidisciplinary Assessment Team (MAT) eligible newly detained children Countywide were referred to MAT. From October 2009 to September 2010, there were 4,806 MAT referrals and 3,552 MAT assessments completed.

In September 2010, 11 DCFS offices referred 90 to 100 percent of all MAT eligible children, two DCFS offices referred 80 to 89 percent of all MAT eligible children, and six offices referred between 70 to 79 percent of all MAT eligible children. All eight SPAs are referring over 70 percent of eligible children and SPA 1 referral rates have increased since the last report. The rate of MAT compliance is depicted in Table 2.

Table 2: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	41	31	76%
SPA 2	91	77	85%
SPA 3	116	100	86%

SPA 4	24	23	96%
SPA 5	13	13	100%
SPA 6	107	78	73%
SPA 7	55	49	89%
SPA 8	61	52	85%
Total number of DCFS MAT referrals:	**508**	**423**	**83%**

* Cumulative includes all September 2010 MAT referrals within each DCFS office and SPA.

MAT staff (DMH, DCFS, and MAT agencies) meet at the SPA level on a monthly basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Best Practice Workgroup, comprised primarily of experienced MAT providers, and managers from both departments have worked to standardize and streamline the MAT process by redesigning the Summary of Findings (SOF) format and have developed new best practice guidelines. One of the workgroup's goals is to improve the quality of MAT reports. To achieve this goal, DMH has provided Strength and Needs-Based Assessment trainings to MAT assessors and both departments are working to develop MAT trainings related to form completion, documentation, and billing.

In addition, the Best Practice Workgroup has worked to overcome barriers that prevent MAT agencies from completing the SOF in time for Court consideration at the dispositional hearing. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders to the MAT agencies. In addition, DCFS MAT Coordinators work closely with the Dependency Court attorneys to ensure that children have the appropriate consents to receive needed mental health services, while DMH MAT Coordinators are closely monitoring the quality of the MAT SOFs and consulting with MAT providers to improve the quality of the reports. MAT staff and other stakeholders have also met to discuss the needs for timely linkage to mental health services. This meeting resulted in the creation of the MAT Linkage Workgroup. This workgroup is tasked with ensuring that children with mental health needs are linked to appropriate services in a timely manner. The guidelines have been created so that each MAT agency understands its new responsibility regarding timely and appropriate linkage to mental health services.

DMH and DCFS have issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol, MAT Quality Assurance checklist, and MAT CSW Interview Survey. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT program.

A preliminary study was conducted with one MAT assessor per SPA utilizing the revised SOF format. Overall feedback from the MAT assessors was very positive as they found the new format to be user-friendly, guided them to be more strengths/needs-based with the child and family, and allowed for more teaming with CSWs and families. As a result, the Best Practice Workgroup plans to implement the revised SOF form Countywide and will coordinate the implementation with aforementioned MAT trainings.

To date, DMH MAT Coordinators have completed a total of 247 MAT Quality Improvement (QI) Checklists. The checklists represent findings based upon a review of the MAT SOF from all eight SPAs. The MAT QI Checklist calls for yes/no responses within eight domains. In addition, DMH MAT Coordinators have completed a total of 141 MAT CSW Interview Surveys. The MAT CSW Interview Surveys calls for yes/no responses within seven domains. The results of the MAT QI Checklists and CSW Interview Survey are summarized below.

<u>Results within MAT QI domains (April 2010 to November 2010)</u>

- 86 percent of the SOFs reviewed showed that the assessors demonstrated reasonable efforts to engage all the stakeholders in multidisciplinary activities to support the information gathering/assessment process;

- 87 percent showed the SOF Report adequately assessed all of the MAT domains of functioning;

- 90 percent showed the SOF Report contained adequate description and information;

- 88 percent showed the SOF final report was completed within 45 days;

- 96 percent showed the strengths of the children, family, and other caregivers were adequately described;

- 92 percent showed the needs of the children, family, and other caregivers were adequately described;

- 94 percent showed the recommendations made in the report were consistent with the assessment information; and

- 97 percent showed the recommendations were specific enough to be efficiently implemented.

Overall, 91 percent of the individual domain ratings were positive.

Results within DMH MAT SOF CSW Interviews (April 2010 to November 2010)

- 85 percent are able to work effectively with the MAT assessor to ensure all relevant information is included in the report;

- 96 percent are satisfied with the extent to which they are able to participate in the SOF meeting;

- 91 percent reported that the SOF Report presented at the SOF meeting provided additional insight and information;

- 89 percent reported that the SOF Report assisted with the development of the service plan with the child(ren);

- 85 percent reported that the SOF Report assisted with the development of the service plan with the family;

- 83 percent reported that the SOF Report further supported the caregivers; and

- 67 percent reported that the SOF Report assisted in the preparation of their report recommendations to the court.

Overall, 85 percent of the individual domain ratings were positive.

Consent/Release of Information

DCFS and DMH, with their respective County Counsels, developed procedures and forms to provide for the consent of mental health services for referred children, as well as the authorization to release protected health information for purposes of children's care and coordination of services. The newly revised authorization to release protected health information became available to DCFS staff in English and Spanish in November 2010. Consent forms and standardized Court language that incorporated recommendations from the Children's Law Center (CLC), the Los Angeles Dependency

Lawyers, County Counsels, Regional Center, and DMH and DCFS management are close to final approval. In addition, CLC is in the process of finalizing a letter intended to provide an explanation regarding consent and protected health information. This letter is also to clarify what information providers may and may not share with DCFS and DMH staff for purposes of children's care and the coordination of services. The DCFS Training section will provide training to staff from both departments on the revised release of information and consent forms.

The DMH Practice Guidelines related to consultation requests involving adult mental health information are near completion and being reviewed by the DMH Quality Assurance Division. The Guidelines include information on the formation of the multidisciplinary teams that may allow DMH co-located staff and service providers to share adult mental health information to assist DCFS in providing protection to children and support to families. DCFS has agreed to create a comparable policy to clarify which situations, within this context, merit consultation with DMH and what information can be shared.

Benefits Establishment

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the Medi-Cal Eligibility Data System (MEDSlite) benefits establishment system. MEDSlite is a condensed version of the Medi-Cal Eligibility Data System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT Coordinators that serves as an instructional guide for the use of MEDSlite, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

Although the MEDSlite system is helpful in providing a child's Medi-Cal eligibility status "at a glance", one of the limitations of the system is that it does not provide the issue date of a child's Medi-Cal card, needed most by DMH providers for mental health service billing. Therefore, DCFS and DPSS have developed a productive partnership through the use of DPSS Linkages staff to obtain and secure Medi-Cal services for children without Medi-Cal that are otherwise eligible.

D-Rate

In addition to the D-Rate Program's continued work to review and ensure mental health services for D-Rate children, the duties of the DCFS D-Rate Evaluators have been expanded to include psychotropic medication monitoring for all DCFS children,

psychiatric hospital discharge planning, special placement requests and approvals, and service coordination for other high-need children.

A recent study conducted by DMH showed that 88 percent of the children placed in D-Rate homes were receiving mental health services and that 35 percent of those receiving mental health services were enrolled in an intensive home-based program, such as Wraparound or Full Service Partnerships. In addition, DMH and DCFS D-Rate staff have been working together to identify D-Rate children not receiving mental health services and promoting service linkages. As of October 2010, there were a total of 1,375 children in DCFS care who were receiving a D-Rate, a number that has been gradually declining over the last several years.

Team Decision-Making/Resource Management Process

DCFS has completed 4,045 Team Decision-Making (TDM) meetings from July through September 2010, a decrease from the previous three months due to temporary reassignments to the ER Over 60 Days Project (April 2010 to June 2010). Additionally, DCFS has completed a total of 275 Resource Management Process (RMP) TDMs on 62 percent of youth entering a group home, 59 percent of youth replaced, and 61 percent of youth exiting a group home. This was an increase of 114 RMPs from the previous three months (April 2010 to June 2010).

Specialized Foster Care

The DMH Specialized Foster Care (SFC) co-located staff responds to requests for consultation from CSWs, provides referral and linkages to community-based mental health providers, and participates in the CSAT process in those offices where CSAT has rolled out. Moreover, all SFC co-located clinicians were trained in Trauma Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, and provide this treatment on a case-by-case basis. Currently, DMH has 178 co-located staff in 18 DCFS regional offices.

In addition, DMH co-located staff participates in a variety of shared practices with DCFS, including TDM meetings, RMPs, MAT SOF meetings, case conferences, and numerous training activities to improve their ability to support DCFS. DMH co-located staff has recently participated in a training to improve their ability to assess and treat children ages birth to five years of age and to properly identify children's strengths and needs, consistent with the CPM.

OBJECTIVE NO. 2

Mental Health Service Delivery

DMH has been working with its provider community to improve capacity and utilization of mental health services, particularly among those providers, now totaling 64, who have received a Katie A. related contract (including Wraparound, MAT, TFC, Comprehensive Children's Services Program, and Basic Mental Health Services). In total, these contracts now provide for over $100 million of targeted mental health services for DCFS children. In addition to these targeted contracts, DMH children's providers also use their general service contracts to provide needed services to DCFS children.

DMH Child Welfare Division staff and service area administrations have begun a series of technical assistance site visits with each of the Katie A. providers to improve their proper utilization of their contracts and maximize their ability to serve DCFS children, and the Child Welfare Division provides monthly reports to providers to monitor their contract utilization. Beginning in January of 2011, quarterly meetings of Katie A. providers will be held to promote improved service delivery and service quality.

DMH has also begun a large scale transformation of mental health services related to the Mental Health Services Act and the Prevention and Early Intervention Program. As part of this initiative, children's mental health providers are being trained in a variety of evidence-based practices, including Trauma-Focused Cognitive Behavior Therapy, Triple P (Positive Parenting Program), Child Parent Psychotherapy, Cognitive Behavioral Intervention for Trauma in Schools, Managing and Adapting Practice, Incredible Years, and Seeking Safety. These practices are expected to significantly improve the quality of children's mental health services and promote improved outcomes.

Wraparound

Wraparound continues to grow and receive very positive feedback from both families and DCFS regional staff as indicated by the scores on the Wraparound Fidelity Index – version 4 (WFI-4). The full WFI-4 Report will be included in the 2010 Wraparound Annual Report, released in December 2010.

As of November 30, 2010, 1,459 children have been enrolled in Tier II Wraparound, which is ahead of the target (1,325) and a number of the Wraparound providers have begun to hire staff to manage the increased referrals. This past quarter, Tier I enrollments have decreased due to program graduations and disenrollments. The

current census is expected to increase significantly with the implementation of the Residentially-Based Services (RBS) Demonstration Project beginning in December 2010. In addition, DMH completed amendments with a number of Wraparound providers to increase the capacity of the program by an additional 817 Tier II slots for DCFS children.

As reported last quarter, there continues to be discussion about the impact Tier II is having on Tier I. The Wraparound Administration is doing a quality review of Tier II cases to ensure that the Tier II criteria are being applied appropriately. The Wraparound Administration has also implemented a review of the Wraparound Case Rate for appropriateness and opportunities to increase the utilization of EPSDT. In May 2010, a workgroup was formed that included representatives from the CEO, Auditor-Controller's Office, DCFS Finance, Probation, DMH, and several Wraparound Provider agencies. The workgroup developed the methodology and the process for evaluation of Wraparound EPSDT utilization. On October 4, 2010, all Wraparound providers received instructions to provide case rate data for review. To date, all providers have submitted their required information and DCFS Fiscal is processing the data. Upon completion, the Wraparound Administration will analyze report findings and discuss next steps.

Treatment Foster Care

The County's TFC Program is another intensive mental health service program, originally discussed in the Katie A. CAP. The target population for TFC is emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. The goal is to provide intensive mental health services in a less restrictive home-like setting as an alternative to congregate care.

Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 TFC beds by January 2008 and the County has been in the process of implementing 80 Multidisciplinary Treatment Foster Care (MTFC) homes and 220 Intensive Treatment Foster Care (ITFC) homes. A proposal to extend the timelines for full implementation is being discussed by DMH and DCFS managers, County Counsel, Plaintiff attorneys, and Katie A. Advisory Panel members.

Currently, the TFC Program growth is steady as the average number of youth entering a TFC Program each month has sustained at a higher rate (5.3 placements/month) than that of the previous FY (2.3 placements/month). Likewise, just during the first half of FY 2010-11, over 33 youth have entered the program; four more than the 29 who entered during the entire previous FY. As of November 30, 2010, the program reached its highest mark with 44 youth receiving intensive services in TFC settings (26 ITFC and

18 MTFC). In addition, since the last report, the seven youth who transitioned out of a TFC program continued the positive trend of graduating to a lower level of care rather than returning back to a group home or psychiatric facility at a rate of 2 to 1 (with the MTFC program slightly outperforming ITFC).

There has also been a significant increase of certified TFC homes since the last report. Twenty-two homes have been added, bringing the total number of certified homes to 69 by the end of November 2010 (35 ITFC and 34 MTFC) with 26 additional homes in the certification process (20 ITFC and 6 MTFC). With added technical assistance from the Los Angeles County Community Development Team (CDT) and out of county MTFC experts, the MTFC Program is reaching its target goal of 80 slots quickly.

The challenge for both TFC Programs, however, remains the length of time needed to recruit, certify, and train potential TFC resource families. Recruiting foster homes is a challenge faced across the State. Once a family is recruited, it can then take between two to six months to complete the consolidated home study and 40 hours of State mandated TFC training to become fully certified. In an attempt to facilitate this process, the DCFS and DMH TFC Program staff is providing additional direction in recruitment strategies and troubleshoot barriers to certification.

ITFC SUCCESS STORY

In October 2010, an ITFC foster parent was awarded legal guardianship for two ITFC siblings who had been in her home for over a year. This foster parent was not only committed to offering a permanent home for these youth, she (along with the ITFC treatment team) worked diligently to develop a positive and ongoing relationship with their mother who was recently released from prison. The paradox of many positive ITFC outcomes, such as this, is that the children obtain a permanent home while the ITFC Program loses a certified home in the process.

Table 3: TFC Placement and Capacity (as of 11/30/2010)

Agency	No. of Placed Children	Certified Homes	Certified Homes Vacancies	**Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
Five Acres	10	15	2	3	5
ChildNet	6	7	1	0	1

Table 3: Continued - TFC Placement and Capacity (as of 11/30/2010)					
Agency	**No. of Placed Children**	**Certified Homes**	**Certified Homes Vacancies**	****Inactive Homes**	**Upcoming Beds**
Olive Crest	2	2	0	0	1
Penny Lane	2	3	2	0	6
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	1	1	0	0
The Village	3	3	0	0	4
CII	0	1	1	0	1
David and Margaret	0	0	0	0	1
Vista Del Mar	1	1	0	0	1
Hathaway-Sycamore	0	0	0	0	0
Ettie Lee	2	2	0	0	0
SUB TOTAL	26	35	7	3	20
Multi-dimensional Treatment Foster Care (MTFC)					
CII	5	7	0	0	0
Penny Lane	8	17	0	10	6
ChildNet	2	5	3	0	0
David and Margaret	3	5	0	2	0
SUB TOTAL	18	34	3	12	6
GRAND TOTAL	**44**	**69**	**10**	**15**	**26**

**Per Agency Request

OBJECTIVE NO. 3

Funding of Services/Legislative Activities

The FY 2009-10 Katie A. budget closed with $22 million in net County cost savings. The savings are primarily due to vacant Wraparound slots. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings should decline in the out years. As we have done with prior year savings, CEO has rolled the FY 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2010-11 and FY 2011-12 in support of the incremental rollout of the Strategic Plan.

The settlement negotiations with the State of California led by Special Master, Rick Saletta, have continued for the past 1 ½ years. Although the transition of the Governor's office has slowed the process, it is now anticipated that a settlement agreement with the State will be reached by the end of the calendar year or early 2011. DMH has continued to participate in the negotiations and this forum remains the County's most viable opportunity to maximize revenue reimbursement to the County.

OBJECTIVE NO. 4

Training

DMH and DCFS have worked closely together to develop and implement the necessary training components related to the Strategic Plan, including:

- On December 3, 2010, DCFS CWMHS provided DCFS 101 and Real Time Notification training to approximately 140 DMH PMRT staff.

- On October 26, 2010, the DMH Child Welfare Division hosted a Katie A. Training overview for DMH district chiefs, managers and supervisors. The DCFS Katie A. Training manager along with a presenter from the California Institute of Mental Health (CIMH) discussed DCFS and DMH CPM trainings, Coaching and Mentoring training for line supervisors, CSAT, and the Enhanced Skill-Based Training (ESBT). All SPAs were represented and informed the details of the continued rollout of the Katie A. training initiatives.

- On behalf of DMH, CIMH will present a one-day Countywide CPM training on February 10, 2011, focusing on key mental health interventions, including Trauma Informed Practice, Engagement, and Strengths/Needs-Based mental health assessments. In addition, CIMH will provide four half-day training

sessions and ongoing phone consultation in each SPA for DMH co-located staff and community providers supported by coaching and case consultation.

- An ER specific Coaching Model has been developed in partnership with California State University, Long Beach. The initial round of ER coaching for Cohort 1 offices will be completed by:

    - Lakewood and Compton: December 14, 2010; Wateridge and Pasadena: December 16, 2010; Chatsworth: December 21, 2010; and Cohort 2 offices (Torrance, Vermont Corridor, Palmdale, Pomona, and Metro North) by January 25, 2011.

- The ESBT for line supervisors began on December 1, 2010 and training for line CSWs will begin on January 11, 2011. The Continuing Services staff coaching begins on January 25, 2011. This core training will provide staff with key skills and techniques to become office-based coaches with back-end staff.

- The DCFS/DMH CPM desk guide will be refined and adapted into a desk guide that aligns both departments' policies and procedures for ER and Continuing Services staff. In addition, the CPM desk guide will articulate how staff will integrate the key competencies of engaging and teaming, while using a strengths-based approach into daily practice.

OBJECTIVE NO. 5

Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,680 (January 2010) to 15,650 (October 2010). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

The individual CSW generic caseload average in October 2010 was 24.97, which is a decrease of 0.5 children per social worker from the July 2010 average of 25.47. The ER caseload showed a significant decrease in July 2010, which brought the referral average to 15.19. The October 2010 average of 17.10 demonstrates the increased number of Child Protection Hotline referrals, an increase in ERCP follow-up referrals, associated workload tied to increased safety measures in emergency response activities and investigations, and the need to address an increasing backlog of emergency response investigations.

OBJECTIVE NO. 6

Data and Tracking of Indicators

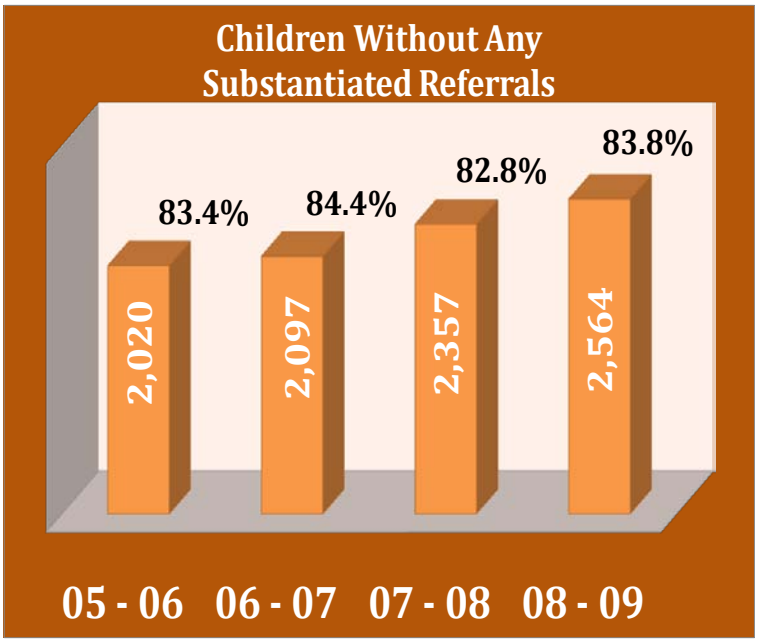
The departments, with approval from County Counsel, implemented a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The SAS Dataflux system is being used for matching DMH and DCFS client data. The SAS Dataflux system is now in full production, whereby matches are being conducted weekly.

Discussions on the exit indicators continue. Should the Court agree with the County and Panel's recommendations on the Safety and Permanency Exit Indicators and targets, the first step in identifying measurable exit criteria by which to evaluate the County's progress in complying with the Katie A. lawsuit would be accomplished.

DATA OUTCOMES

SAFETY	***PERMANENCY/ REDUCED OUT-OF-HOME CARE***

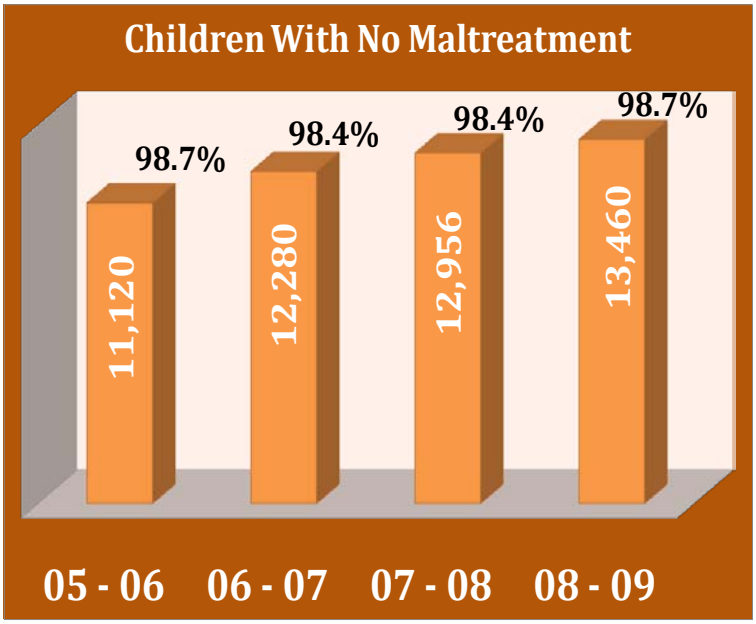
The intensified collaboration of the departments to advance the objectives of the Strategic Plan simultaneously impacts DCFS key goals to: 1) improve child safety; 2) decrease timelines to permanency and reduce reliance on out-of-home care; and 3) improve child well-being. A sample of Katie A. Safety and Permanency Exit Indicators for class members (those receiving mental health services) are depicted below and have not changed since the last quarterly report in September 2010.



Safety Indicator 1:

Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

This indicator has remained fairly stable over the last few years at roughly 83 percent and demonstrates that the majority of children are remaining safely at home.



Safety Indicator 2:

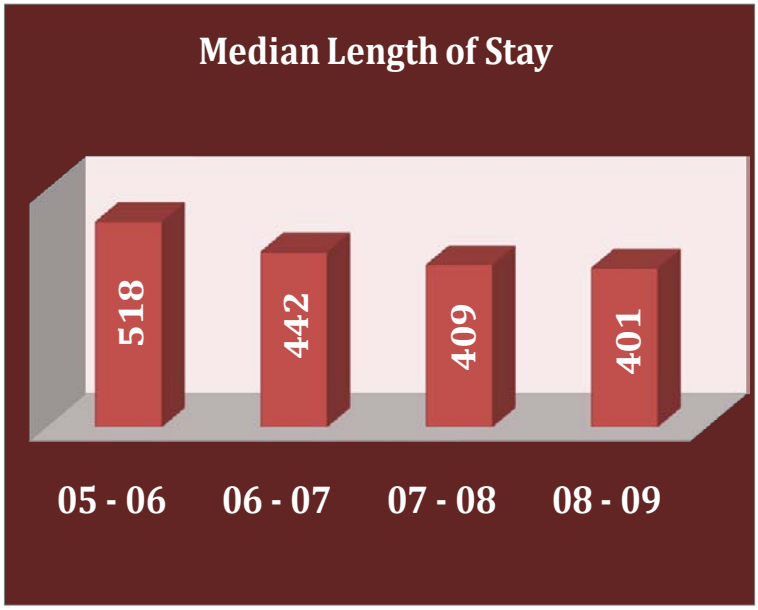
Of all children served in foster care in the fiscal year receiving mental health services, how many did not experience maltreatment by their foster care providers?

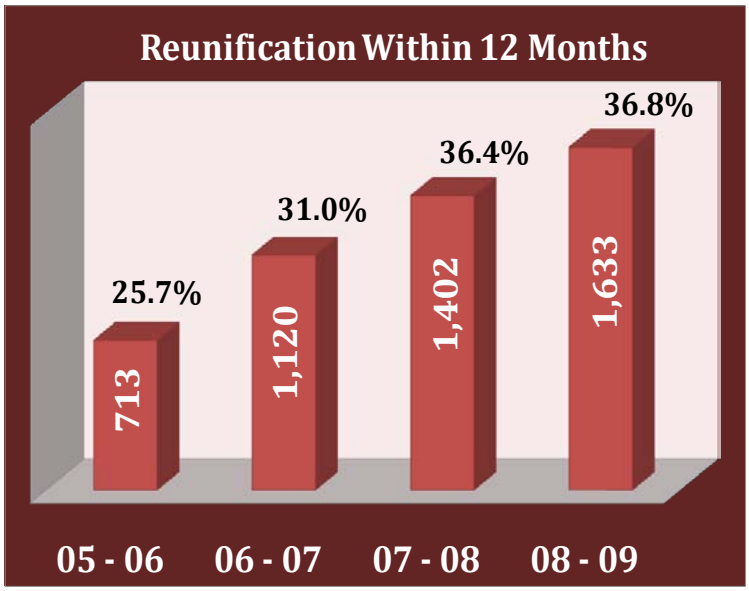
Again, this indicator has remained stable at 98 percent indicating that the majority of children in foster home settings experienced no substantiated foster parent maltreatment.

Permanency Indicator 1:

Median length of stay for children in foster care receiving mental health services.

This indicator reflects meaningful improvement – a 23 percent decline – in median days in foster care from FY 2005-06 to FY 2008-09.





Permanency Indicator 2:

Reunification within 12 months for children receiving mental health services.

Dramatic improvements in reunification are evident – over 100 percent increase from FY 2005-06 to FY 2008-09.

OBJECTIVE NO. 7

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the: (1) successful adoption by your Board and the Federal District Court of the Strategic Plan; (2) acceptable progress on a discrete set of agreed upon data indicators; and (3) a passing score on the Quality Services Review (QSR).

Quality Services Review

The QSR provides an in-depth, case-based review of the front-line DCFS practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services. The QSR is not a tool used for compliance enforcement, as its feedback is used to stimulate and support practice development and capacity building efforts leading to better practice results for DCFS children and families.

The QSR protocol examines recent results for children in protective care and their caregivers, the contribution made by local service providers and the system of care in producing those results. In addition, the QSR protocol contains qualitative indicators that measure the current status of the focus child, and the child's parents and/or caregivers, while also measuring the quality and consistency of core practice functions used in the case.

A total of 42 cases have been randomly selected for review since July 2010. An average of 8.8 children, youth, caregivers, family members, service providers, and other professionals were interviewed per case and the results have been consistent across the three DCFS offices reviewed – Belvedere, Santa Fe Springs, and Compton. Overall, the children in the cases reviewed were found to be safe, healthy, and well cared for. On the Child and Family Status Indicators, close to 80 percent of the cases had favorable outcomes, with 100 percent of the children identified as being safe in the home of the parent or substitute caregiver at the time of the review. The Practice Performance Indicators identified areas for improvement, including Engagement, Teaming, and Long-Term View. Other factors that were found to have an impact on outcomes included the positive correlation between case outcomes and continuity of the CSW; the utilization of trauma informed evidenced-based treatments; the completion of early assessments that address underlying needs of the child and family; implementing a team approach to treatment; and developing a shared vision with clear goals to be

achieved for safe case closure. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

QSR Phase II activities, which are to be completed by December 2012, have begun, including the commencement of the administration of the QSR across the 18 DCFS regional offices. The initial sequence of offices to undergo reviews in 2011 has been identified and the rollout is expected to generally follow the order of the CSAT implementation and Enhanced Skill-Based Training. The 2011 QSR schedule includes eight reviews beginning in the DCFS Vermont Corridor Office, January 24-28, 2011. DCFS and DMH are on target to meet the projected time frames to issue the QSR findings and a final report in December 2012, in compliance with the Katie A. Settlement Agreement. QSR Phase III activities, to be completed by December 2013, will consist of any follow-up reviews that may be necessary to achieve passing scores.

QSR reviews have provided an opportunity to understand what is working well and where there is an opportunity for growth. DCFS and DMH have been developing a shared CPM, Enhanced Skill-Based Training, and Coaching and Mentoring Program, so there is a consistent method of practice in working with children and families. In addition to these change strategies, the departments are implementing regional based improvement plans to strengthen practice and ensure quality services.

Summary Highlights

During the last three months, the County has continued to demonstrate significant progress towards meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Katie A. implementation updates will transition to a semi-annual reporting schedule in 2011, with the next report issued on June 30, 2011.

Significant highlights from the last report include:

- DMH has provided contract amendments with Wraparound Providers that will expand the County's capacity to provide Wraparound services for DCFS-involved children and youth by an additional 817 slots;

- DMH and DCFS have begun a series of technical assistance site visits to work with Wraparound Providers and other Katie A. funded mental health programs to improve utilization and reporting of Katie A. related funds;

- The contracts for the RBS Demonstration Project were finalized on December 2, 2010 and the Project is currently operational and serving 49 youth;

- A contract amendment has been provided to Exodus to provide mental health crisis stabilization services to DCFS involved children and youth. A coordinated joint response between PMRT and the existing CSW is now occurring for all PMRT field responses for DCFS-involved children during regular work hours. For PMRT field responses to DCFS children who are not hospitalized after regular work hours, a real-time notification and follow-up process by DCFS is currently in place.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Assistant Chief Executive Officer, at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:KH
LB:AM:mh

c: Executive Office, Board of Supervisors
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WILLIAM T FUJIOKA
Chief Executive Officer

July 21, 2011

To: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN SEMI-ANNUAL UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system in fulfillment of the objectives identified in the Katie A. Settlement Agreement.

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

Implementation Support Activities

DATE	DESCRIPTION
October 2010	The Department of Mental Health (DMH) has contracted with Exodus Urgent Care Center to provide urgent mental health services to DCFS children and youth ages 13 and above.
February 2011	DMH and Department of Children and Family Services (DCFS) have developed a protocol for responding to children with acute and urgent mental health needs. This protocol requires that services be initiated within no more than 24-hours for acute cases and three days for urgent cases. In addition, the mental health provider must prepare a timely written report to DCFS detailing the client's status, services provided and services planned.
April 2011	DMH and DCFS staff reviewed approximately 50 DCFS cases that have received a mental health screening. These cases were evaluated to determine fidelity to the Coordinated Services Action Team (CSAT) protocol and the appropriateness of the response.
May 2011	DMH was given the approval to hire eight additional positions to augment the Psychiatric Mobile Response Teams (PMRT) response to emergency calls involving DCFS children and youth. DCFS has also reassigned four positions to assist DMH with the coordination of emergency responses to DCFS children and youth.
May 2011	Enhanced Skill Based Training (ESBT) has been rolled out to 65 percent of Line Supervisors and 30 percent of Children's Social Workers (CSWs). In addition, all DMH Service Planning Area (SPA) 6 contracted mental health providers have been trained in the foundation of the Core Practice Model (CPM).
June 2011	To date, 78 cases have been randomly selected for Quality Service Review (QSR) from seven DCFS regional offices. Review findings are currently being utilized by local DCFS leaders and practice partners to support efforts to improve practice.

OBJECTIVE NO. 1
Mental Health Screening and Assessment

Medical Hubs

In Fiscal Year (FY) 2010-2011, approximately 70 percent of newly detained children received an Initial Medical Examination at a Medial Hub (Hubs). On February 22, 2011, the County implemented the Enterprise Medical Hub (E-mHub) system. The E-mHub system was developed to strengthen the continuity of care by the Department of Health

Services (DHS)-operated Hubs and to improve information sharing between DCFS and the Hubs. The E-mHub system is expected to significantly improve the percentage of priority population children served by the Hubs and will contribute to the reduction of the "no-show" rate. As part of a joint effort between DHS and DCFS, the E-mHub system accepts the electronic transmission of the DCFS Hub Referral form and returns the resulting appointment status to DCFS via e-mail notification to the currently assigned CSW, Supervising Children's Social Worker (SCSW), Public Health Nurse (PHN), PHN Supervisor and respective CSAT staff.

Coordinated Services Action Team - Redesign

The CSAT process requires expedited screening and response times based upon the urgency of a child's needs for mental health services. As a result of a January 2010 Board Motion and subsequent case review, the Child Welfare Mental Health Screening Tool (MHST), the CSAT Screening and Assessment Policy, and the related DMH practice guidelines were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs identified. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. The CSAT redesign training and implementation will be complete in August 2011.

Multidisciplinary Assessment Team

In March 2011, 89 percent of all eligible newly detained children Countywide were referred to the Multidisciplinary Assessment Team (MAT). From April 2010 to March 2011, there were 5,092 MAT referrals and 3,616 MAT assessments completed.

Table 1: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	49	20	41%
SPA 2	52	51	98%
SPA 3	61	61	100%
SPA 4	46	46	100%
SPA 5	7	7	100%
SPA 6	103	89	86%
SPA 7	65	64	98%
SPA 8	47	45	96%
Total number of DCFS MAT referrals:	**430**	**383**	**89%**

It is important to note that the low referral rate in SPA 1 is due to MAT Provider capacity. Currently, there are only four MAT Providers in SPA 1, where most other SPAs have 10 or more. Although several SPA 1 MAT agencies are having difficulty filling positions due to the shortage of eligible staff candidates in the area, when the shortage of MAT capacity is limited, the DMH Specialized Foster Care (SFC) staff is able to prepare a comprehensive mental health assessment.

In addition, the revised MAT Summary of Findings (SOF) report was modified to improve its quality and was released Countywide in March 2011. A total of six trainings were conducted to orient and train over 200 MAT providers and County staff to the new format. In addition, monthly consultation calls provide staff the opportunity to review cases and assist with the development of strength-based assessments that address underlying needs. The MAT protocol has also been revised to improve service linkage following the MAT SOF and to clarify the role of the MAT team in addressing placement needs.

From April 2010 through May 2011, DMH MAT Coordinators have completed a total of 397 MAT Quality Improvement (QI) Checklists and 213 MAT CSW Interview Surveys. Overall, 91 percent of the QI checklist eight domain ratings were positive and 86 percent of the MAT CSW Interview Surveys seven domain ratings were positive.

D-Rate

DMH and DCFS have begun to review the needs of D-Rate children and the mental health services offered to them in an effort to better identify the programmatic needs of this population and to make reforms to the D-Rate program that could offer a more defined place on the DCFS/DMH spectrum of care. After careful review, DCFS and DMH determined that the MAT SOF reports (performed within the prior 12 months) contain clinically relevant information needed to establish D-Rate eligibility and will now be integrated into the child's placement and treatment planning. Although this process has just begun and is not subject to formal procedural guidelines, this new practice appears to be more efficient, less costly and has subjected children to fewer assessments.

In addition, DCFS and DMH have met to discuss the enhanced coordination between Wraparound services and Treatment Foster Care (TFC) utilizing D-Rate certified foster parents and relative caregivers. Although these discussions are preliminary in nature, DCFS and DMH are exploring the increased level of intervention available to D-Rate children and the degree to which D-Rate caregivers are able to receive additional support and guidance from Wraparound providers cross-trained in the TFC model.

Team Decision-Making/Resource Management Process

DCFS has completed 4,880 Team Decision-Making (TDM) meetings from November 2010 through February 2011 - a 17 percent increase from the previous report. Additionally, DCFS has completed a total of 568 Resource Management Process (RMP) TDMs on 52 percent of youth entering a group home, 53 percent of youth replaced, and 45 percent of youth exiting a group home. This was an increase of 218 RMPs from the last report.

OBJECTIVE NO. 2
Mental Health Service Delivery

Specialized Foster Care

The DMH SFC co-located staffs respond to requests for consultation from CSWs, provide referral and linkages to community-based mental health providers, offer treatment services when necessary, and participate in the CSAT process in those offices where CSAT has rolled out. Currently, DMH has 178 co-located staff in 18 DCFS regional offices. In addition, DMH is working with its provider community to improve capacity and utilization of mental health services, particularly among those providers not fully utilizing their Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) contracts, now totaling 64. These contracts now provide for over $120 million of targeted mental health services for DCFS children, including Wraparound, TFC, and MAT. Over 40 percent of the children with a current DCFS open case are receiving mental health services. DMH Child Welfare Division staff and service area administrations continue to engage in a series of technical assistance site visits with each of the Katie A. providers to improve proper utilization of their contracts and maximize their ability to serve DCFS children.

Wraparound

As of April 30, 2011, 2,082 children have been enrolled in Tier II Wraparound, which is ahead of the projected target (1,775). Tier I enrollments (1,033) have increased due to the temporary suspension of the RMP enrollment requirement to Tier I and the implementation of the Residentially-Based Services (RBS) program.

The Wraparound program is also undergoing a major redesign process in preparation for the new contract in 2014. Five workgroups were created to address the different focus areas: Fiscal, Contracts, Program, Practice, and Quality Improvement/Assurance. The objective of these workgroups is to make Wraparound more efficient and incorporate lessons learned, new advances in the field, and feedback

from consumers and community stakeholders. In addition, the County continues to discuss the impact of the two-tiered case rate system for Wraparound Tier I - $4,184 (inclusive of placement) and Tier II - $1,250 (exclusive of placement). To address this issue, the fiscal redesign workgroup has begun looking to combine the two rates and to maximize the use of EPSDT to support Wraparound services. The workgroup members have conducted a cost analysis of Tier I to help inform the case rate discussion and the development of new Wraparound contracts. DMH has continued to increase mental health contracts to support the expansion of the Wraparound program and has now provided EPSDT funding to support 3,115 Wraparound slots.

Treatment Foster Care

The target population for TFC is for the most emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. TFC provides an alternative to group home care for these children by providing intensive in-home therapeutic and behavior management services in a foster home with a limit on the number of children placed in that home. Although TFC program placements and contracts have increased, program growth was slowed due to time consuming and costly requirements placed on foster parents. Potential foster homes were required to obtain approval for foster as well as adoptive care. As a result, DCFS executive management has now waived this requirement for all TFC foster parents and will begin the process for modifying existing contracts with the Board of Supervisors.

Table 2: TFC Placement and Capacity *(as of April 30, 2011)*

	No. of Placed Children	Certified Homes	Certified Home Vacancies	Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
	36	46	6	7	13
Multidimensional Treatment Foster Care (MTFC)					
	21	36	6	9	0
Grand Total	***57***	***82***	***12***	***16***	***13***

Overall, a total of 125 youth have received TFC services. Sixty-eight youth have transitioned out of the program with half recidivating to a higher level of care and the remainder graduating to a lower level of care (i.e. home of parent, legal guardian, relative and/or foster home). The success of TFC is also evidenced by those youth who remain stable in their TFC placements as this is a successful step toward permanency, pro-social stability, and as a result, present the County with a significant annual fiscal savings.

In June 2011, DCFS and DMH TFC staff developed a workgroup to increase the delivery of intensive treatment services to DCFS-involved youth (particularly those youth in D-Rate homes). Since the target populations for the TFC, Wraparound and D-Rate programs share similar needs, behaviors and risk factors, the DCFS/DMH workgroup will explore ways of utilizing existing Wraparound and D-Rate resources to provide a more flexible array of therapeutic services for the TFC target population. In addition, this workgroup will review and analyze the differences between those youth who have recidivated versus those who graduated from the TFC program.

OBJECTIVE NO. 3
Funding of Services/Legislative Activities

The FY 2010-11 Katie A. budget closed with $16 million in net County cost savings. The savings are primarily due to vacant Wraparound slots. As done with prior year savings, Chief Executive Office (CEO) has rolled the FY 2010-11 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 and FY 2012-13 in support of the incremental rollout of the Strategic Plan.

The County has been informed that the settlement negotiations with the State are concluding and that a proposed settlement has been reached. The Court has directed the Special Master to submit his report detailing the settlement recommendations by July 22, 2011. Future updates will be provided when available.

OBJECTIVE NO. 4
Training

DCFS and DMH have developed curricula that encompass training for CSWs, co-located DMH staff, and community mental health providers to "Enhance Practice Skills". ESBT offers an overview and rationale of the content as well as training towards Strengths-Needs Based Practice, Engagement, and Teaming. To date, ESBT has been rolled out to 65 percent of Line Supervisors and 30 percent of CSWs In addition, along with the Los Angeles Training Consortium, DCFS has implemented coaching for Emergency Response (ER) supervisors to reinforce the ESBT in all DCFS offices. In July 2011, the DCFS Executive Team will be provided coaching sessions to teach and reinforce a strength-based approach for working with staff and constituents and to bolster their support of their workers and supervisors' ongoing participation in ESBT and coaching.

In April 2011, DMH completed the first of a 2-day CPM training for the SPA 6 children's mental health providers. This four-module training uses a train-the-trainer approach and will be subsequently provided to mental health providers in the remaining service areas

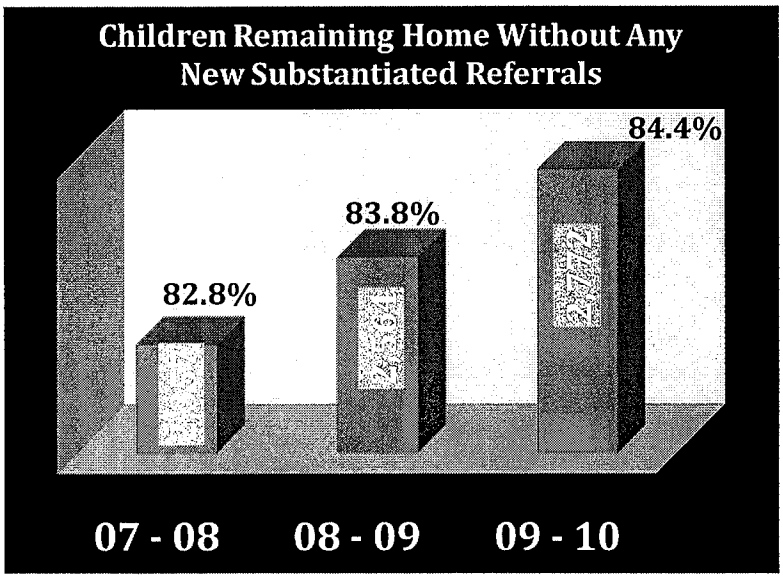
by September 2011. This classroom training will then be augmented by a series of coaching calls and meetings to support the implementation of the CPM. In addition, training has been provided to Specialized Foster Care, MAT and Wraparound providers in the key practice areas of: Cultural Competency, Needs-Based Assessment, Family Engagement, Dual Diagnosis, Crisis Management and mental health interventions with the birth to five population and their families.

OBJECTIVE NO. 5
Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,650 (October 2010) to 15,429 (April 2011). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

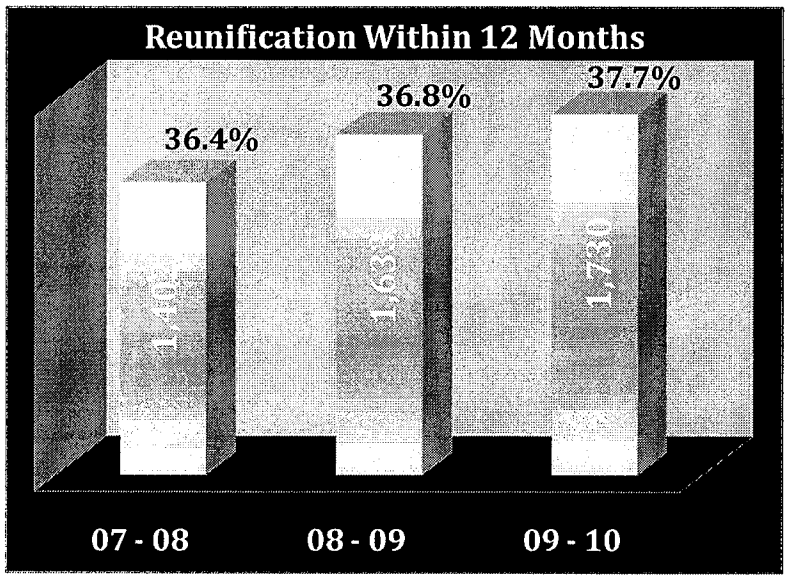
The individual CSW generic caseload average in April 2011 was 26.79, which is an increase of 1.82 children per social worker since October 2010 (24.97). The ER caseloads also depict a slight increase in number of referrals from October 2010 (17.10) to April 2011(17.5). These increased caseload averages reflect ongoing parallel ER over 60-day investigations. Both the generic and emergency response averages represent the seasonal fall and early spring Child Protection Hotline referral peaks. These peaks also generate an increase in Emergency Response Command Post follow-up referrals, increased workload related safety measures in emergency response activities/investigations and caseload averages.

OBJECTIVE NO. 6
Data and Tracking of Indicators



Safety Indicator 1:

Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.
The FY 09-10 (through March 2010) demonstrates that the majority of children are remaining safely at home.



Permanency Indicator 1:

Reunification within 12 months for children receiving mental health services.

Improvements in reunification are evident.

OBJECTIVE NO. 7
Exit Criteria and Formal Monitoring Plan

Quality Services Review

The Quality Service Review (QSR) provides an in-depth, case-based review of the front-line DCFS and system partners practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services.

To date, 78 cases have been randomly selected for review. An average of nine children, youth, caregivers, family members, service providers and other professionals, per case, have been interviewed and the results have been fairly consistent across the seven DCFS regional offices reviewed – Belvedere, Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Lancaster and Palmdale. On average, 86 percent of the cases across the offices are scored favorably on the Child and Family Status Indicators and roughly one-third of the cases scored favorably on the System Performance Indicators. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

The QSR schedule for 2011 includes: Pomona (July 11th), El Monte (August 22nd), Glendora (October 3rd), and Pasadena (November 14th). The remaining offices will be reviewed during the 2012 calendar year.

SUMMARY HIGHLIGHTS

DATE	DESCRIPTION
Ongoing	CPM, ESBT, Coaching and QSR training continues to roll out to both DCFS and DMH staff and providers to improve practice.
Ongoing	DMH and DCFS continue to enhance the implementation and coordination of the high-needs service delivery spectrum of TFC, Wraparound and D-Rate.
May 2011 – 1st Quarter 2012	Implementation planning is underway for the PMRT–Expedited Response Pilot, including hiring, development of DCFS policy and procedures, and tracking system.
July 2011	The County has been informed that the settlement negotiations with the State are concluding and that a proposed settlement has been reached. The Court has directed the Special Master to submit his report detailing the settlement recommendations by July 22, 2011.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Assistant Chief Executive Officer, at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

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LB:AM:mh

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WILLIAM T FUJIOKA
Chief Executive Officer

December 23, 2011

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN SEMI-ANNUAL UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system in fulfillment of the objectives identified in the Katie A. Settlement Agreement.

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

Implementation Support Activities

DATE	DESCRIPTION
May - December 2011	The Departments of Children and Family Services (DCFS) and Mental Health (DMH) completed implementation planning on the joint Field Response Operations Expedited Response Pilot (FRO ERP),which included hiring, development of DCFS policy and procedures, DMH practice guidelines, training, and a tracking system. A formal process has been established to provide for the timely notification, identification, and response to DCFS children/youth experiencing acute and/or urgent mental health needs to ensure better individualized safety plans for children. This protocol ensures communication between FRO and DCFS when the FRO team responds in person to a child, but does not hospitalize the child. All efforts will be tracked and evaluated for efficacy and improved outcomes for children.
August 2011	DMH and DCFS initiated a protocol to ensure the rapid sharing of information for children and youth who are identified as having "urgent" mental health needs. The protocol requires that services for these referrals are initiated in no longer than three days. The mental health provider is also required to complete a form describing the services provided and plans for future services, and fax this to DCFS within no more than seven days. This form is then uploaded into the client's case record in the Child Welfare Services/Case Management System (CWS/CMS). The protocol also emphasizes the need for ongoing communication on shared child welfare and mental health cases for the purposes of coordinating care.
September 2011	Enhanced Skill-Based Training (ESBT) has been rolled out to 95 percent of Line Supervisors and by May 1, 2012 over 60 percent of Children's Social Workers (CSWs) will have been trained. A training and coaching pilot in the Compton Office is scheduled to begin in November with complete rollout by January 2012. The pilot will emphasize the importance of both formal and informal teaming.
November 2011	The Directors of DCFS, DMH, and Probation issued a joint letter to all staff formally endorsing the Core Practice Model developed in consultation with the Katie A. Panel.

December 2011	A Policy Memo from the Interim Director of DCFS was released to all staff specifically addressing the increase of young children in group homes and reinforcing the department's efforts to reduce the number of children and youth in group home care.
December 2011	DCFS implemented a data tracking report through the interface between DHS' E-mHub System. This will enable DCFS to track on a child-specific basis the population of newly detained children who are referred and not referred, to a Medical Hub (Hub) for an Initial Medical Exam, and which child-specific children are being seen, and not seen, at the Hub.
December 2011	The State's Katie A. Settlement Agreement as well as the County's Exit Conditions were approved by the Federal Court. The County began participating in state workgroup meetings in early October to operationalize the key objectives of the state settlement agreement.
December 2011	DCFS, DMH, County Counsel, the Chief Executive Office (CEO), and children's mental health providers met with Tim Penrod from Arizona's Child and Family Support Services to discuss intensive home-based mental health services and lessons learned from Arizona's class-action lawsuit and the development of their mental health system.

OBJECTIVE NO. 1
Mental Health Screening and Assessment

Medical Hubs

Since the Countywide implementation of the E-mHub System, DCFS has developed a data tracking report through the interface between the E-mHub System on the priority population of newly detained children being served at the medical hub(s). Once this report is finalized, it will be generated monthly and will provide child and office specific tracking/compliance data on DCFS newly detained children who are referred to and have received an initial medical exam at a hub. The E-mHub System provides scheduling detail and reports the results of the initial medical exam, forensic exam, mental health screening results, and referral form status in real-time back to the CSW. The system will enable the department to track the medical hub compliance rates much more effectively than the manual process used in the past.

Beginning in December, DCFS will implement a recommendation from the Katie A. Panel's October report requesting that a small sample of newly detained children not referred to the hubs be reviewed more closely to determine reasons for non-referral. The study will focus on interviewing CSWs and/or Supervising CSWs (SCSWs) to better understand the reasons why

newly detained children were not referred to a hub for an initial medical exam. Based on the findings from the study, a corrective action plan will be developed by March 2012 to address the newly detained, non-referrals to the hubs.

Coordinated Services Action Team - Redesign

The Coordinated Services Action Team (CSAT) process requires expedited screening and response times based upon the urgency of a child's needs for mental health services. As a result of a January 2010 Board Motion and subsequent case review, the Child Welfare Mental Health Screening Tool (MHST), the CSAT Screening and Assessment Policy, and the related DMH practice guidelines were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs identified. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. CSAT has been implemented in all 19 Regional Offices and each CSAT Team is currently coordinating regular CSAT monthly meetings to promote teaming among all DCFS and DMH resource staff to better serve the needs of families. These CSAT meetings will serve as an open forum for each resource staff to troubleshoot and address challenges that hinder the timely delivery of services (i.e., mental health, medical, placement, family finding, Medi-Cal eligibility, etc.) to families. Additionally, many CSAT teams are working with the DMH D-rate and Family Preservation (FP) program managers to develop processes to streamline and prevent a duplication of mental health service delivery when a child is referred to DMH Specialized Foster Care co-located staff and also accepted by a FP provider agency for a D-rate placement.

Multidisciplinary Assessment Team

In September 2011, 97 percent of all eligible newly detained children Countywide were referred to the Multidisciplinary Assessment Team (MAT). From July 2010 to September 2011, there were 6,352 MAT referrals and 4,775 MAT assessments completed.

Table 1: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	20	17	85%
SPA 2	77	74	96%
SPA 3	83	80	96%
SPA 4	51	51	100%
SPA 5	5	5	100%
SPA 6	75	70	93%
SPA 7	80	80	100%

SPA 8	51	51	100%
Total number of DCFS MAT referrals:	**442**	**428**	**97%**

In an effort to address a long standing provider capacity deficit in SPA 1, DMH successfully negotiated with two additional MAT providers who have agreed to provide MAT assessments in Service Planning Area (SPA) 1. Specialized Foster Care (SFC) staffs in all SPAs continue to prepare a comprehensive mental health assessment, if necessary, when a child is not eligible or capacity lacks to conduct a MAT Assessment.

From July 2010 through August 2011, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 45 days. The expected timeline for completion is 45 days. The percentage completed in 45 days or less was approximately 61 percent. The percent completed by the 50th day was 78 percent. DCFS MAT Administration is currently creating a process to directly e-mail the MAT SOF Reports to the court and attorneys to reduce the time lag in receiving timely MAT reports.

In terms of completing the MAT assessment by case disposition, DCFS MAT Coordinators report approximately 70 percent of MATs are completed prior to disposition. The remaining 30 percent are delayed for numerous reasons including:

1. Variance in timelines to disposition within the court process. While DMH MAT providers have 45 days to complete the assessment, disposition can occur prior to the 45 days;
2. CSW compliance in obtaining consent/referral documents delayed some initial MAT referrals, thereby delaying the timeline to completion;
3. Benefits establishment, including verifying/troubleshooting Medi-Cal and Medi-Cal applications; and
4. Toward the end of the fiscal year, there were provider capacity issues in several SPAs, which delayed the acceptance of referrals.

On November 21, 2011, DMH hosted the First Annual Countywide MAT Provider's Meeting, providing a forum to discuss MAT history, progress and information with all MAT providers. DMH is also in the process of updating the CSW Interview Guide and Quality Assurance (QA)/Quality Improvement (QI) Checklist to align with Core Practice Model (CPM) values and Quality Service Review (QSR) indicators. DMH plans to conduct audits on MAT charts in the near future using these tools to measure the SOF Reports. DMH will also be providing Strengths and Needs-based Trainings to further assist MAT providers with improving the quality of their SOF reports.

From August 2011 through October 2011, DMH MAT Coordinators completed a total of 97 MAT QA Checklists and 52 MAT CSW Interview Surveys. Overall, 95 percent of the QI

Checklist's eight domain ratings were positive and 84 percent of the MAT CSW Interview Survey's seven domain ratings were positive. Areas rated positive include improved ability to work effectively with MAT assessors, satisfaction with their participation in the SOF meeting, useful information provided in the SOF meetings to aid CSWs in the development of service plans for children and families, and learning about and utilizing resources. Areas rated challenging included difficulty scheduling meetings due to time constraints, problems clarifying roles and responsibilities of team members, and difficulties when court orders specific modalities of treatments.

D-rate

As of September 30, 2011, a total of 1,313 children placed in out-of-home care received the D-rate. DMH and DCFS have continued to review the needs of D-rate children and the mental health services offered to them in an effort to better identify the programmatic needs of this population and to make reforms to the D-rate program that could offer more defined service provisions on the DCFS/DMH spectrum of care.

In addition, DCFS and DMH have created a workgroup that meets to discuss the enhanced coordination between Wraparound services and Treatment Foster Care (TFC) utilizing D-rate certified foster parents and relative caregivers. Although these discussions are preliminary in nature, DCFS and DMH are exploring the increased level of intervention available to D-rate children and the degree to which D-rate caregivers are able to receive additional support and guidance from Wraparound providers cross-trained in the TFC model, which could provide a more flexible and robust continuum of services.

Team Decision-Making/Resource Management Process

DCFS has completed 8,219 Team Decision-Making (TDM) meetings from March 2011 through August 2011 - a 12 percent increase from the previous report. Additionally, DCFS has completed a total of 1,026 Resource Management Process (RMP) TDMs on 66 percent of youth entering a group home, 69 percent of youth replaced, and 54 percent of youth exiting a group home. This was an increase of 14 percent for group home entry TDMs, 16 percent for replacement TDMs, and a 9 percent increase for group home exits from the last report.

DCFS has developed stricter gate-keeping provisions to mitigate the number of children 0-12 entering group homes. The provisions consist of the following:

- Placement of children age eight years and younger in a group home will no longer be permitted without the approval of the Chief Deputy or Director.

- For any group home placement packet to be generated, the signatures of the CSW, SCSW, Assistant Regional Administrator (ARA), and Regional Administrator (RA) must be obtained confirming that an RMP team meeting has occurred prior to placement or within one week of placement when an RMP cannot take place in advance.

- For any youth approved for placement in a group home, a mandatory referral to the department's family finding program, called Permanency Partners Program (P3), must be made at the time of placement (except for those enrolled in Residentially Based Services (RBS), which has its own family finding component).

- For any youth placed in a group home, a regular family team meeting coordinated and facilitated by the case carrying CSW or SCSW should occur on a monthly basis at minimum.

- For any child age 12 years or younger, a Permanency Planning Conference (PPC), a family team meeting coordinated and facilitated by a PPC Facilitator, should occur once every four months. The signature of the CSW, SCSW, ARA and RA is required on the PPC plan. Additionally, a monthly tracking report will be coordinated and produced by the Resource Management Division, with an assignment to RAs to update the report with the current status and plan for transitioning to the community.

OBJECTIVE NO. 2
Mental Health Service Delivery

Specialized Foster Care

The DMH Specialized Foster Care (SFC) co-located staffs respond to requests for consultation from CSWs, provide referral and linkages to community-based mental health providers, offer treatment services when necessary, and participate in the CSAT process in those offices where CSAT has rolled out. Currently, DMH has 178 co-located staff in 18 DCFS regional offices. In addition, DMH is working with its provider community to improve capacity and utilization of mental health services, particularly among those providers not fully utilizing their Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) contracts, now totaling 64. These contracts now provide for over $120 million of targeted mental health services for DCFS children, including Wraparound, TFC, MAT and enhanced mental health services.

DMH continues to see improvements in the utilization of mental health services by DCFS-involved children. At present, 60 percent of the children and youth who are the subject of an open DCFS case are either receiving mental health services or have received mental health services during their current DCFS case.

Wraparound

As of November 11, 2011, 1,128 Tier I and 1,398 Tier II slots were filled, which is 60 percent of the targeted 4,200 slot rollout. Tier I enrollments have increased due to the increase in the Adoptions Assistance Program (AAP) utilization, the ongoing suspension of the RMP enrollment requirement to Tier I, and the implementation of the RBS program.

The Wraparound program is undergoing a major redesign process in preparation for the new contract in 2014. Five workgroups were created to address the different focal areas: fiscal; contracts; program; practice; and quality improvement/assurance. The first phase of the Wraparound redesign process (workgroup recommendations) is complete and now the Wraparound Administration is preparing for the second phase (analysis of the recommendations from the workgroups). The fiscal workgroup is finishing up and is expected to complete their analysis in December.

Once the Wraparound Administration compiles all the recommendations, they will be discussed with the existing Wraparound providers. The Wraparound Administration will analyze the recommendations and start the draft of the Statement of Work (SOW) by March 2012. The SOW will then be posted for public comment and finalization by the end of 2012.

Treatment Foster Care

The target population for TFC is the most emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. TFC provides an alternative to group home care for these children by providing intensive in-home therapeutic and behavior management services in a foster home with a limit on the number of children placed in that home. Although TFC program placements and contracts have increased, program growth was slowed due to time consuming and costly requirements placed on foster parents. Potential foster homes were required to obtain approval for foster as well as adoptive care. As a result, DCFS executive management has now waived this requirement for all TFC foster parents and will begin the process for modifying existing contracts with the Board of Supervisors.

Table 2: TFC Placement and Capacity ***(as of November 30, 2011)***

	No. of Placed Children	Certified Homes	Certified Home Vacancies	Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
	40	62	9	13	15
Multidimensional Treatment Foster Care (MTFC)					
	20	39	7	11	7
Grand Total	***60***	***101***	***16***	***24***	***22***

Overall, a total of 156 youth have received TFC services. Of the 94 youth that have transitioned out of the program, 55 percent graduated to a lower level of care (i.e., home of parent, legal guardian, relative and/or foster home) while the remainder recidivated to a higher level of care. The success of TFC is also evidenced by those 62 youth who currently remain stable in their TFC homes. These youth are supported by a unique team dedicated to the provision of their needs and are now successfully moving towards permanency and pro-social stability. It was additionally determined that this program presents the County with a significant annual fiscal savings of approximately $1.8 million in fiscal year (FY) 2010-11, as a result of meeting youth needs in community settings when compared to congregate care services.

In June 2011, DCFS and DMH TFC staff established a workgroup comprised of managers and supervisors from CEO, DCFS, and DMH to increase the delivery of intensive treatment services to DCFS-involved youth (particularly those youth in D-rate homes) as well as to identify resources for targeted recruitment and fine-tune foster parent retention strategies. The Workgroup will also review and analyze the differences between those youth who have recidivated versus those who graduated from the TFC program. Both departments are collectively preparing for an upcoming TFC foster parent training/recruitment event planned for February 17, 2012.

Another effort that is underway to address TFC is a D-rate/TFC pilot project proposal that would effectively cross train contracted provider staff who manage TFC contracts and Wraparound Programs on TFC principles. In efforts to move forward with the pilot project, both departments have encountered barriers related to contracting, solicitation, and regulatory issues. The Workgroup consulted with other municipalities who currently operate successful TFC programs to discuss best practices and how they use multiple funding streams to finance their TFC programs. The goal has been to increase the viability and sustainability of the County's TFC program. The departments are continuing to meet to discuss and identify possible solutions to these barriers, participating on two related State Workgroups, as well as consulting with County Counsel.

OBJECTIVE NO. 3
Funding of Services/Legislative Activities

Currently, the FY 2011-12 Katie A. budget depicts approximately $11.3 million in net County cost savings. The savings are primarily due to vacant Wraparound slots.

In December 2011, settlement negotiations with the State concluded and the Federal Court formally approved the State Settlement at the December 1, 2011 Fairness Hearing. Leadership staff from both DCFS and DMH has been participating on the Katie A. State Settlement Implementation Workgroup since early October to operationalize the key objectives of the settlement agreement. The Workgroup is comprised of state and County Katie A. leadership,

legal representation and several other Katie A. stakeholders. One of the focal areas this group is working on is to develop a billing manual that will provide guidance on billing issues for care and supervision that fall under Title IV-E as well as mental health services that should be captured under EPSDT.

Other promising news to report is that the Federal Court approved the County's Exit Conditions in December 2011. This is a huge step forward for the County in developing measureable exit criteria to demonstrate compliance with the County's settlement agreement, which eventually will advance the County's exit from Court oversight.

OBJECTIVE NO. 4
Training

DCFS Training

DCFS and DMH have developed curricula that encompass training for CSWs, co-located DMH staff, and community mental health providers to "Enhance Practice Skills". Enhanced Skill-Based Training (ESBT) offers an overview and rationale of the content as well as training towards strengths-needs based practice, engagement, and teaming.

To date, ESBT has been rolled out to 95 percent of DCFS Supervisors and by May 1, 2012, over 60 percent of CSWs will have received ESBT. In addition, along with the Los Angeles Training Consortium (LATC), DCFS has implemented coaching for supervisors to reinforce the ESBT in all DCFS offices.

Additional "Coaching to Child Welfare" Seminars are being planned for TDM facilitators, other line DCFS SCSWs, co-located DMH staff and others who have an opportunity to consistently model a strengths–needs based approach to working with families.

Finally, to further enhance the quality and knowledge base of Coaches from September 8, 2011 to November 9, 2011 over 60 DCFS, DMH, Inter-University Consortium and LATC coaches have taken QSR training. The goal is to have the majority of coaches participate as QSR Reviewers by the end of FY 2011-12.

DMH Training

In September 2011, DMH completed the two-day Core Practice Model (CPM) training provided by California Institute for Mental Health (CIMH) for the DMH SFC co-located staff, DMH directly operated clinics and children's mental health contract providers. This four-module

training used a train-the-trainer approach with a specific focus on clinical supervisors and clinical leads.

Training was completed Countywide and approximately 78 contract providers, seven directly operated children's clinics, and 18 DMH SFC co-located sites were trained. A total of 382 supervisors and lead clinicians were trained Countywide. In addition, training has been provided to SFC, MAT and Wraparound providers in the key practice areas of: cultural competency, needs-based assessment, family engagement, dual diagnosis, crisis management and mental health interventions with the birth to five population and their families.

Integration of Coaching Efforts

On September 29th DMH and DCFS met with the LATC to contract for delivery of coaching services to the Compton DCFS office which is considered the pilot office. DCFS and LATC have provided coaching to Compton for the last six months. The contract with LATC will augment coaching capacity from a two-hour session per month to three full days of coaching per week and will include coaching to DMH staff and contract providers. A total of 18 "external" coaches will be assigned to the Compton office, comprised of eight DCFS training staff, eight LATC staff, and two DMH staff.

The current DCFS, DMH and LATC coaches have participated in the Enhanced Skills Based Training and the QSR training. These coaches have a good foundation to communicate and demonstrate the core practice model expectations for the Compton office. Coaches and staff will be assigned one family to follow from case inception to termination. Coaches will prepare mental health providers separately from DCFS staff, but will integrate mental health providers when necessary to meet the needs of the family. Coaches will work with mental health providers on clarifying their roles and expectations during child and family team meetings.

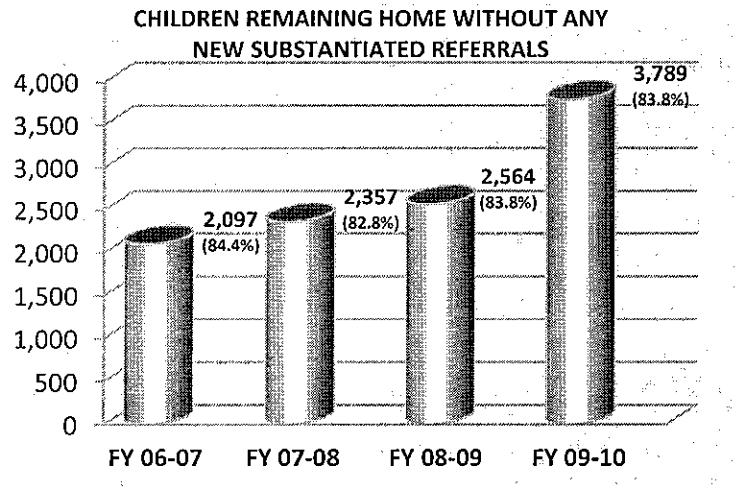
OBJECTIVE NO. 5
Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,429 (April 2011) to 15,390 (September 2011). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, the Department is allowed to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

The individual CSW generic caseload average in October 2011 was 27.05, which is a very slight increase of .26 children per social worker since April 2011 (26.79). The ER caseloads also depict a slim increase in number of referrals from April 2011 (17.5) to October 2011 (17.10). These elevated caseload averages continue to reflect ongoing parallel ER over 60-day investigations. Both the generic and emergency response averages tend to increase with

the seasonal fall and early spring Child Protection Hotline referral peaks. These peaks also generate an increase in Emergency Response Command Post follow-up referrals, increased workload related safety measures in emergency response activities/investigations and caseload averages.

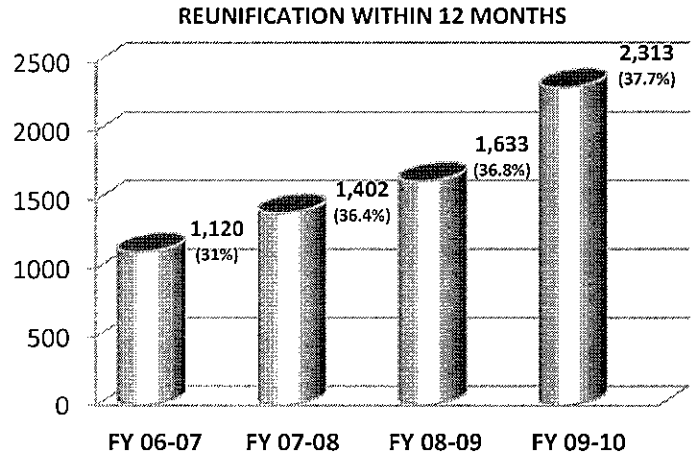
OBJECTIVE NO. 6
Data and Tracking of Indicators



Safety Indicator 1:

Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

Since FY 2006-07, there has been an 81 percent increase in the number of children remaining home without any new substantiated referrals.



Permanency Indicator 1:

Reunification within 12 months for children receiving mental health services.

Improvements in reunification are evident since the number of children reunified has more than doubled since FY 2006-07.

OBJECTIVE NO. 7
Exit Criteria and Formal Monitoring Plan

Quality Services Review

The QSR provides an in-depth, case-based review of the front-line DCFS and system partners practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services. To date, 128 cases have been randomly selected for review. An average of 10 children, youth, caregivers, family members, service providers and other professionals, per case, have been interviewed and the baseline results demonstrate consistent themes and patterns across the 11 DCFS regional offices reviewed: Belvedere; Santa Fe Springs; Compton; Vermont Corridor; Wateridge; Lancaster; Palmdale; Pomona; Glendora; El Monte; and Pasadena.

On average, 87 percent of the cases across the offices have scored acceptably on the Child and Family Status indicators while roughly 40 percent of the cases scored favorably on the System Performance Indicators.

Based upon the reviews conducted thus far the following practice lessons have been identified: engaging families and giving voice and choice to children, parents and caregivers in decision making enhances understanding and participation, leading to better outcomes; strength-based identification of needs helps gain understanding of underlying needs and treatment of trauma required for true and lasting change to occur; improved long-term view provides a clearly articulated vision and guides all the work toward safe closure; better teamwork improves the functioning of the total support system around the family to unite, communicate, and coordinate actions toward the case plan goals and following case closure. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

The remaining offices of the first QSR Cycle will be reviewed during the 2012 calendar year in the following order: San Fernando Valley (January 17th); West San Fernando Valley and Santa Clarita (February 22nd); Metro North (March 19th); West Los Angeles (April 22nd); Torrance (May 14th); and South County (June 4th).

SUMMARY HIGHLIGHTS

DATE	DESCRIPTION
Ongoing	CPM, ESBT, coaching and QSR training continues to roll out to both DCFS and DMH staff and mental health service providers to improve practice.
Ongoing	DMH and DCFS continue to enhance the implementation and coordination of the high-needs service delivery spectrum of TFC, Wraparound and D-rate.
December 2011	Katie A. Exit Conditions for the County were approved by the Federal Court and the Court approved the state's settlement agreement.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Lesley Blacher, Manager, at (213) 974-4603, or via e-mail at lblacher@ceo.lacounty.gov.

WTF:BC
LB:lb:yw

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Mental Health

Katie A Semi-Annual December 2011.final